Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 0.0 5 21501

ysician		State Registrar Decedent's Name (First, Middle, Las	•		Cei	rtificate	of Dea	ath	2. Date of De	Reg. No. aath Day	Year	3. Time of Death
Medical		Alice Virginia H							9	17	200	
caminer	4	a. Facility Name (If not institution, give		1 0			Town, or Loca			1	County of Dea	
	5	Peninsula Region 5. Social Security Number 6. Se			iter ast birthday)	Sa1	isbury	nder 24 Hrs.	8. Date of Bir		Wicomi	
eral ctor			M ≱EF	86	Yrs.	Months		ours Min.	01 16	ay, Year)	0	rthplace (State or Fore ountry) MD
any injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	1	Oa. State 10b. County			, Town or Lo	cation						10d. Inside City Lim 1 Yes 2 ☐
Director	2	MD Worcest Worcest Wo	er	Snow	HI11	10f. Zip (Code			10a Citi:	zen of What C	ountry?
	5	302 Belt St.								_		ouray.
Jera	1	11. Marital Status	12. Was Decedent I	Ever in U.	S. 13. \		.863 ent of Hispan	ic Origin? (Sr	pecify Yes or No Rican, etc.)	US - 1	4. Race - Am	
by Funeral	D. A.	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	No			ify Cuban, Me ⊠ No Spa		Rican, etc.)	1	Black, Whi	
e		15. Decedent's Ed	ucation		16a. Deced	dent's Usual	Occupation				nd of Business	
Completed		(Specify only highest grade	de completed) College (1-4or 5	i+)			k done during e retired) Worker		king	Po	ultry	
Ö		17. Father's Name (First, Middle, Last)			100				ne (First, Middle		• • • • • • • • • • • • • • • • • • • •	
To Be		Levin Kelly						Lizzie	Rayne			
-		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	ng Address	(Street and N	lumber or Ru	ral Route Numb	er, City or	Town, State,	Zip Code)
		Susan Pruitt (d	aughter)		410) W. F	'ederal	St.	Snow Hi	11.	MD 218	11
	2	20a. Method of Disposition		20b. P	lace of Dispo	sition (Nam	e of		Date		cation - City or	
		1 ♣ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			emie I			9/21/	/2006	Sn	ow Hil	1, MD
BC	1	21. Signature of F eral Service Licens	s oo						ne Burba erlin, M			Home
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	rications that caused one cause on each lin	the death					-		011	Approximate Interval Between Onset and Death
an cal		Immediate Cause (Final disease or condition resulting in death)	a. Respira	atory	Failu							Days
ner			b. Myocard			rtion						Days
<u> </u>		Sequentially list conditions, frany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as									Days
Examiner	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Cause (Disease or injury that initiated events resulting in death) Last	c. Severe Due to (or as	Inop a consequ	erable uence of):	Mult	i-Vess	el Cor	conary I)isea	se	Years
ledical Examir	200	•	d									
by Physician/M	1 2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 [X]No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3 [Ectopic pre Other (spe				2	3d. Date of de Month	elivery Day Year
by Ph	ב ב	Part II. Other significant conditions co	ontributing to death bu	ut not resu	ılting in the ur	nderlying ca	use given in l	Part I.		obacco u		to the cause of death?
eted	-								,	185 21	7140 2 TL	Tobably 4 Monking
Completed	-								24a. Was auto perfo	psy ormed?	prior to death?	utopsy findings availa completion of cause s 2 \(\sum \) No
tion: To Be (2	25. Was case referred to medical examiner?	Mill and Co				26.	Place of Dear	th (Check only o			
ို		1 ☐ Yes 2 ☑ No	Hospital: 1X Inpatie	nt 2 🗆 I	ER/Outpatien			☐ Nursing H	ome 5 Resi	dence 6	☐Other (Spe	ecify)
ü	2	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury		Sc. Injury at Work?		28d. Describe	how injury	occurred	
ca		2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At ho	me, farm, stre	M eet, factory.	1 Tes	2 🗆 No	28f. Location (Street and	i Number or F	Rural Route Number,
al Cer		29a Cartifier 1X Cartifying Phy	raidan: To the best o	of my know	wledge death	n occurred a	it the time; de	te and place;	and due to the	enusals)	and concern	ic stated.
	<u></u>	(Check only 2 Medical Exam	iner: On the basis of and manner sta	examinat ited.	ion and/or inv	vestigation, i	in my opinion	, death occur	red at the time,	date and	place, and du	e to the cause(s)
edical		29b. Signature and title of certifier	0000				License num				7	nth, Day, Year)
Medic												
completely		1 (now	MM	_			004	1069		71	201	2006
		30. Name and add s of person who c	completed cause of de	eath (Item	23a) (Type,	Print)	004	1069		41	201	2006 5008/m

			For State Registrar	State of	Marylan	id / Depa <i>Cei</i>	artment rtificate	of H	ealth a D <i>eath</i>	and M	lental Hyg	iene2	006	315	502
			Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	th Day	Year	3. Time of	Death
	Physici /Medio		Lawrence Edward	lIngberg							Septemb			1:00	P M
	Examir		4a. Fecility Name (If not institution,		nber)				Location of	of Death			ounty of Death		
		М	400 Woodcrest A		7. Age (In yrs.	(ast hirthday)	Sali If Under			24 Hrs.	8. Date of Birth		icomico		or Foreign
	Funeral Director		213-24-4186	1 <u>M</u> M 2□F	77	Yrs.		Days	Hours	Min.	(Month, Day Jan. 29	, Year) , 1929) Mary	lece (State on htry) Land	, r a oign
	ס		Usuel Residence of Decedent		1.2.20										2 1 2 - 2 -
1	anylan ehow	_	10a. State 10b. County		10c. Cit	y, Town or Lo							1	0d. Inside C	ity Limits 2∭No
2	he Me 18a-f	Director	Maryland Wicomic	0		Salis	bury 10f. Zip (Codo.				On Citizer	n of What Cour		
X	with t	급	400 Woodcrest Av	eniie				804					USA	, .	
1/2	death me 23	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Decede	ent of His	spanic Ori	gin? (Sp	ecify Yes or No-		Race - Americ		
ဖွ	after or Ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed For 1 XYes If Yes, Giv	2 □ No Te	als	ites,speci 1 □ Yes 2	_	n, mexican Specify:		Rican, etc.)	S	Black, White, pecify:	oc. √hite	
93	ural',	d by	3 Widowed 4 Divorced	Year or Da	ites: Uliki	ilowii									
15	n 72 i	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual kind of worl DO NOT use	done d retired)	ation furing mosi)	t of work	ing	16b. Kind	of Business/In	oustry	
12	iene. iene. r than	шо	Elementary/Secondary (0-12)	College (1 2	-4or 5+)		tor M					Fede	ral Gov	ernmer	ıt
PC	al Hyg other	Be C	17. Father's Name (First, Middle, La	ist)				1	18. Mothe	er's Name	e (First, Middle,	Maiden Su	ımame)		
Vlar	Menta Menta arked	To	Simon Hanson Ing	berg					В	lanc	he McMar	nis			
lan	2 shc		19a. Informant's Name/Relationship								al Route Number	1,00			
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		Margaret J. Ingh	erg/Wire	20b. F	400 W Place of Dispo cemetery, crer					Salisbur Date		aryland tion - City or To		<u> </u>
nor	ages on of it.		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State				į.	/16/	1				
Ħ	artme ortan injur		21. Signature of Funeral Service Li		2 n 1	natory o					'2006 e, P. O.		r, Dela	aware	
B	Dep Per Per Per Per Per Per Per Per Per Per		Deneul	12	lle		eller 212 0	1d 0	eral cean	Home	e, P. O. y Road,	Salis	soury,	MD 218	302
			23a. Part. Enter the disease, or co shock, or heart failure. List or	omplications that can't on e	aused the deat ach line.	th. Do not ent	er the mode	of dying	g, such as	cardiac	or respiratory arr	est,	0.7420	Approximat Interval Bet	ween
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	/Medical Examiner		resulting in death)	Due to (or as a conseq	quence of):		10	301-	- ^-	- 1				
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	ted nsit	nine	Cause (Disease or injury	500101	(4)	71									
Ć.	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	quence of):									
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, P.O	The law requires that the death certificate te has been signed by the attending physoge 2 should be detached for use as the		Part II. Other significant condition	s contributing to de	eath but not res	sulting in the u	nderlying ca	iuse give	n in Part I		23e. Did to	bacco use	contribute to t	ne cause of	death?
rds	quires in sign	ed by		MF							15%	es 2 🗆 I	No 3 ☐ Prob	oably 4 🗍	Jnknown
S	law requir as been s 2 should	plet									24a. Was a	an a	24b. Were auto	psy findings	available
R		Completed									perfor	medit 2 🗆 No	death?	212 No	
/ita	Physician: r this certificatal director.	Be (25. Was case referred to medical examiner?					211		of Deat	h (Check only or	10)			
of \	Physi this c	2	1 Yes 2 No			ER/Outpatier 28b. Time o			4 🗀 190	ursing Ho	me \$12 Resid		Other (Special	y)	_
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Division of Vital Records,	Attendir r death. ector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place	of Injury - At h	ome, farm, str	reet, factory,	office			28f. Location (S City or Tow		Number or Run	al Route Num	iber,
Ö	s afte	Cert	4 Homicide determin	Dulidi	ng, etc. <i>(Specil</i>	<i>'y')</i>					City of You	n, State)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completel, filled in by the funeral director.	edical	(Check only 2 Medical E	Physician: To the	asis of examina	owledge, deat	h occurred a	at the tim	ne, date an pinion, dea	nd place, ath occur	and due to the o	ause(s) ar	nd manner as s lace, and due to	tated. the cause(s	5)
	the hin 2, the f	Med	one) 29b. Signature and title of certifier	and mani	ner stated.		-		number				signed (Month,		
	Twit os		230. Signature and time of certains	1		m		00	PG	20		91	11510	1(0	
			30. Name and address of person w	ha complete cause	e of death (Iter	m 23a) (Tyne	Print)	1	0. 10	0	10mL c	00.3	on Ch	ot=	
			An	150	SUN	150	J	V	1	1	10Th & Pocomoke	t eres	ar Stre	1851	
K.		ate	31. Date filed (Month, Day, Year)		egistrar's Signa	ature	1								
	Regist	rar	SEK F	9 2006	The same	Co 2	4000								

ORIGINAL

			1 - For Registrar	State of Maryla		artment of F			ene 1. No. 2006	3150
	Physic /Medi	cal	Decedent's Name (First, Middle, Last SENOR	A L. JI	ENKINS			2. Date of Death Month Sept	Day Year 16, 2006	
1	Funeral	ner	4a. Facility Name (If not institution, give Shady Grove Nt 5. Social Security Number 6. Se	irsing Home	rs. last birthday)	Rockvi It Under 1 Year Months Days		8. Date of Birth (Month, Day,)		
	Director		Usual Residence of Decedent 10a. State 10b. County	10 J	City, Town or Lo	ocation		Aug 24	,1905 VZ	10d. tnside City Limits
	with the Ma a or 28a-f s be notified	Director	MD Montgo		D	LCKersor		100	g. Citizen of What C	1 Twes 2 No ountry?
9036	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f show dical Examinar must be notified at	d by Funeral	20925 Big Wood 11. Marital Status 1 Never Married 2 Married 3 Woldowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1			0 8 4 2 dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	U.S. A 14. Race - Am Btack, Whi Specify:	erican tndian,
Maryland 21215-0036	filed within 72 h Hygiane. Ather than "natu ant, the Madical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 4th	ication le completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired NESTIC	during most of worki	ng	Home	/Industry
ıryland	2 should be fi and Mental H ie marked ott aumatic ever	To Be	17. Father's Name (First, Middle, Last) John Fisher 19a. Informant's Name/Relationship (Ty	rpe. Print)	19b. Mailir	ng Address (Street	18. Mother's Name Saral and Number or Rura	h Scott		Zin Codel
Baltimore, Ma	ss 1 end 2 of Haalth a litem 27 is r other trai		Estelle Lee-Dat 20a. Method of Disposition 1 X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	2100] Place of Dispondentery, cremetery, cremetery		oods Rd 1	Dickers	on, MD 2	20842 Town, State
Baltii	permil. Page Department Important: If any injury or	-	21. Simal re of Funeral Sarvice Licens	maga	64 2	Name and Addre		owden Fron St Re	ockville	ITE, MD IOME, PA e, MD20850
)	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failuge. List only of timediate Cause (Finat disease or condition resulting in death)	ications that caused the dene cause on each line. PNEUMC Due to (or as a consi	ONIA	er the mode <i>o</i> t dyin	g, such as cardiac <i>o</i>	r respiratory arrest	i,	Approximate Interval Between Onset and Death 5 Days
8760,	death certificate be executed e attending physicien and d for use as the burial-transit	ledicai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a const						
Box 6		Physician/Me	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. tf yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etat death 3	Ectopic pregnancy Other (specify)			23d. Date of dei Month	livery Day Year
ords, P.	equires thaten signed and signed and signed	þ	Part II. Other significant conditions cor		esulting in the ur	nderlying cause give	en in Part I.			o the cause of death?
al Rec	130 446	Completed	Coronary Arter Transient Isch		ks			24a. Was an autopsy performed	d'? death?	topsy findings available completion of cause of
of Vit	Attending Physician: r death. sctor: After this certification the funeral director.	To Be	27. Manner of Death	lospital: 1 tnpatient 2 2			4 Lagransing Hon		e 6 Other (Spe	cify)
É	5 g g c	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of tnjury (Month, Day Year) 28e. Place of tnjury - At building, etc. (Spec	home, farm, stre		Yes 2 □ No		et and Number or Ru	ıral Route Number,
	To the Hospital within 24 hours e To the Funeral Completely filled	Medicai (29a. Certifier 1 Certifying Physics (Check only 2 Medical Examinate)	sician: To the best of my kner: On the basis of examinand manner stated.	nowledge 3.a.th nation and/or inv	estigation, in my or	ie data und placa, a pinion, death occurre	nd due to the eaus	e(s) and manner as and place, and due	statud. to the cause(s)
	나 보 보 보 보 보 보 보 보 보 보 보 보 보 보 보 보 보 보 보	2	29b. Signature and title of certifier			29c. License D28			Date signed (Monti Sept. 18	
	Sta Registr		30. Numarical of person who co Ravi Passi, MD 31. Date filed (Month, Day, Year)	8609 Secon	d Ave	•	lver Spr	cing, MI	20910	

06-07263 Charles Joseph Jo	ohn	son	St	Plea ate of Man				in Blac				ne				
	F	- For State legistrar			, , , , , , , , , , , , , , , , , , , ,			e of De					g. No. 2	200	6 315	50
Physician Medical Examine	" er	1. Decedent's Nam Charles	Joseph Jo	ohnson								ite of Death onth ptember		Year 3	3. Time of Death 1225 hrs	
	1	4a. Facility Name (2317 Blue l			number)				y, Town, o	or Location o		<u>, </u>	4c. Cour	nty of Deat	n	
Funeral		5. Social Security I		6. Sex	7. Age	(In yrs. la	ast birthda		nder 1 Ye	ar If Unde	er 24Hrs 8. D	ate of Birth	_	(YY) 9. Bir	thplace (State or	
Director		219-74-43		1 M 2	F		46	Yrs. Mo	nths Da	ys Hours	Min. Ju	me 18,	1960	Foreig	ountry Oregon	
âuâ		Jsual Residence o 10a. State	10b. County			10c. City,	Town or L	ocation							10d Inside City L	imits
and Fshow	5	Maryland	I	Montgomery			Wi	neaton							1 Yes 2X	No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Inportant; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other tranmatic event, the Medical Examiner must be notified at once.	Direct	10e, Street and Nu 2317 B		e Avenue,	Apt. 2	211		10f. 2	Zip Code	2090	02	100	Citizen of		ntry? SA	
er death with , or items 23.	nuera 	11. Marital Status 1 X Never Marri	ied 2 M		Decedent Ed Forces?	Ever in U.	S. 13	. Was Dece If Yes, spe	edent of H ecify Cuba	ispanic Orig an, Mexican	gin? (Specify ` , Puerto Rican	Yes or No- , etc.)		ace - Amer hite, etc.	ican Indian, Black,	
s after c		3 Widowed		orced If Yes, Give or Dates:	Year		1			o specify.			Specif			
2 hours "natur	nai -	15. Decedent's E Elementary/Sec									kind of work do use retired)	one	16b. Kind of	Business/	Industry	
vithin 7	palaidillo				9 (1-4 or 5- 5+			Cler	k					Reta	ail	
215-(be filed to the Hyginrked oth ent, the	ווי	17. Father's Name Thomas Jo		Last)							's Name (First, on LeQues		aiden Surnai	me)		
MD 21215-0036 and 2 should be filed within 7 hand Mental Hygiene in 27 is marked other than animatic event, the Medical To Be Comple		9a. Informant's Na	ame/Relations							et and Num	ber or Rural R	toute Numb				
and 2 s ealth ar em 27	111 2	Thomas J	Tohnson/E	ather		20b. F		Skyline sposition (N			, Front				530 Town, State	
nore	ı		X Cremation		I from Stat	e c	rematory of	or other place. tan Cre	ce)		Septemb					
Baltimore, permit. Pages 1 at Department of He important: If ite injury or other it	2	21. Signa re of Fu	Other Springer		1	1120				-	Funeral			mria,	Virginia	
Physician	12	3a. Part I. Enter th	cheller ne disease, or	ome lications that	it caused t	he death	Do not en	500 Un	iversi	ity Blv	d, W, Si	lver S	pring,	MD 209	Approximate Int	orval
/Medical	1	failure. List or	nly one cause	n each line.	ure Di				o o ajing	, 000, 100 0	ar arao or reoph	idiony direct	rt, orlook, or	riedit	Between Onset Death	
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ficate by the but	1 2:	F FEMALE: 3b. Was decedent	pregnant in th		s, outcome e birth		nancy	erME.g8		0/5/06	II			of delivery		
D. Box 68760, the death certificate be by the attending physicicited for use as the burn Physician/Med	Sicial	past 12 months	5?	4 Pre	e birtri egnant at ti known	ime of dea	2 ath 5	Fetal dear		Ectopic	pregnancy		Month) [Day Year	
ires that the de signed by the de de detached for the de		art II. Other signi	ificant conditi	ons contributing	g to death	but not re	sulting in t	the underly	ng cause	given in Pa	rt I. 2				the cause of death	
ds, Fequires een sign build be				 -								1 Yes 4a. Was an			topsy findings avai	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burnedical Certification: To Be Completed by Physician/Med								Te			1	autopsy perform Yes 2	ed?		completion of cause	e of
/ital sician: is certif	3 2	5. Was case refer examiner?	-	Hospital: 1	Inpatien	t 2	ER/Outpat	tient 3	26.Plac	e of Death (Check only on Nursing Hom		esidence 6	Other	Scano	_
n of Vi ling Physi After this funeral dir	2	7 Manner of Deat	2 No	28a. Da	ite of Injury		28b. Time			ury at Work			w injury occi		- Cerie	
Vision or Attendi fler death Director: in by the f		1 X Natural 2 Accident	5 Pend	ing tigation		_				Yes 2						
Division o spital or Attending hours after death meral Director: After filled in by the fune Certification:		Suicide Homicide		not be mined (Speci		iry - At no	me, rarm,	street, facto	огу, опісе	building, etc		ocation (Str r Town, Stat	eet and Nun te)	nber or Ru	ral Route Number,	City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	2 (9a. Certifier 1 Check only 1 1 1	Certifying Ph Medical Exar	ysician: To the t niner:On the bas and manne	is of exam	knowledg ination ar	ge, death o nd/or inves	ccurred at t	he time, d	late and plan, death occ	ce, and due to curred at the tir	the cause(me, date an	s) and mann id place, and	ner as start d due to th	ed e cause(s)	
	2	9b. Signature and	title of certifie		Stated			2	9c. Licen	se number		2	29d. Date sig	gned (Mor	nth, Day, Year)	
3 2	_	a	rol	Hall	Ra	1_			O.C.	M.E.		:	Septemb	er 27, 2	006	
	3	Name and addr Carol Allan,		who completed ca sistant Medica			,	nn Street	, Baltim	ore, MD	21201					
State Registra	e 3	1. Date filed	P ^{Day} 2 ^{ea}	2006	Registrar's	s Signatur	re do	W)								

Registrar

			1 - For State Registrar	State	e of Maryla	and / D	epartme <i>Certific</i>	ent of F ate of	lealth ar <i>Death</i>	nd Mental I	Hygien Reg. N		31505
	Physici		1. Decedent's Name (First, N Lila, Juppe	iddle, Last)						2. Date o	Death	ay Year	3. Time of Death
<u>}</u>	/Medic Examin		4a. Facility Name (If not instit			10.		-	r Location of I	Death	1	c. County of Dea	
	Funeral		University of 5. Social Security Number	6. Sex	Medica 7. Age (In y	rs. last birt	hday) If Un	der 1 Year	If Under 24	Hrs. 8 Date of	Birth Day, Year	1V/	thplace (State or Foreign
	Director		148-20-3964 Usual Residence of Deceden		· · · · · · · · · · · · · · · · · · ·	31	rs.	Dayo	710070	JUN	7 192!	5 NEW	JERSEY
	ehow	'n	10a. State 10b. Co		10c.		or Location						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a-f	Director	MD 10e. Street and Number	TALBOT		E.A.	STON 10f.	Zip Code			10g. C	itizen of What Co	
	ath with	ralD	27886 HALEY					210				USA	
38	72 hours efter death with the Maryland naturel', or iteme 23a or 28a-1 ehow disal Evariliner must be incillised at	by Funeral	11. Marital Status 1 Never Married 2 3 Nover Married 4 Divo	Married 1 1 1	Decedent Ever in ed Forces? Yes 2\(\) No s, Give or Dates:	ı U.S.		ecedent of H specify Cuba s 20 No	lispanic Origir an, Mexican, I Specify:	n? (Specify Yes o Puerto Rican, etc.	No-	14. Race - Ame Black, Whit Specify: W	
215-0036	ithin 72 hours ne. nen "naturel", • Medical Eva	Completed	(Specify only hi Elementary/Secondary (0-		ge (1-4or 5+)	16a.		work done Tuse retired	ation during most o	of working	16b.	Kind of Business	/Industry
	e filed within Il Hygiene. other than "	0	12 17. Father's Name (First, Mid		2		HOMEM	AKER	18. Mother's	s Name (First, Mid	idle, Maide	OWN HOM on Sumame)	E
ylan	▼ 5 5 €	To B	ALOIS J. WEG	MAN					AL]	CE C. F	SCH		
Maryland 2	12: har 7:e		19a. Informant's Name/Relat)		-			or Rural Route Nu EASTON,			Zip Code)
ore,	of Hee		20a. Method of Disposition 1 Burial 2 Tremat			o. Place of	Disposition (Name of	- 1	Date		Location - City or	Town, State
Baltimore,	permit. Page Depertment important: if eny injury or once.		4 Donation 5 Othe	r (Specify)	Com State	CHESAL	_			TR 9/10/2	2006 8	STEVENSV	ILLE, MD
Ba	Deperiment of the periment of			///	lean	1	DICT T	OTTO T	ss of Facility IELFENE	BEIN & NI	WNAM	FUNERAL	HOME PA
	Physician /Medical Examiner	X X	23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	- a ^	hat caused the done ach line. 1 yourd e to (or as a cons	ial.	Intar	node of dyir	ng, such as ca	ardiac or respirato	ry arrest,	10 21 0 01	Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	e to (or as a cons	sequence o	ot):						
68760,	ficate be executed physicien and is the burial-transit	edical Ex	resulting in death) Last	d	e to (or as a con-	sequence	of):				-		
O. Box	ath cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 CL 4 CP	s, outcome of pre live birth 2 F Pregnant at time of Jinknown	etal death	3 □Ectopii 5 □ Other	c pregnancy (specify)	,			23d. Date of de Month	livery Day Year
rds, P.	w requires that the de been signed by the e should be deteched f	by	Part II. Other significant con	ditions contributing	to death but not	resulting in	the underlyin	ig cause giv	en in Part I.		id tobacco		o the cause of death?
Vital Records,		Completed								a	Vas an utopsy erformed? es 2 N	prior to death?	utopsy findings available completion of cause of 2 No
<u> </u>	ıysiclen: Th is certificete director, pag	To Be	25. Was case referred to me examiner? 1 Yes 2 No	Hospital:	1 ⊠Inpatient 2	2 ☐ ER/Out	nationt 3	DOA Oth	00	f Death Check or ing Home 5 F		6 □Other (See	O.F.)
Division of	Attending Phi death. ctor: After thi y the funeral o	Certification; T	E C / tooldont	nding (estigation	Date of Injury Month, Day Year	28b. T		28c. Injur Wor		28d. Descr		ury occurred	City
DIX	ii or Atten efter deal i Director: d in by the	ertific		uld not be termined 28e. F	Place of Injury - A puilding, etc. (Spi	it home, fai ecify)	m, street, fac	tory, office		28f. Location City or	on (Street a Town, Sta	and Number or Ri te)	ural Route Number,
	To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: Affer this certifical completely filled in by the funeral director.	edical	29a Certifier 1 Cert (Check only one)	itying Physician: T ical Examiner: On t and	the best of my the basis of exam manner stated.	knowledge ination and	Jeath Securi Vor investigat	red at the fir tion, in my o	ne, date and pinion, death	place, and due to occurred at the til	the eause(: ne, date ar	s) and manner as nd place, and due	s stated. e to the cause(s)
ı	To t To t	Σ	29b. Signature and title of ce	/	sident			29c. Licens		C 17447	1 / 2	ate signed (Mont	h, Day, Year)
	10		30. Name and address of per Jesse Mes	son completed		Item 23a) (Type, Print)			5m17442	1	71, 01	Hero
	Sta Registr		31. Date filed (Month, Day, Y		32. Postrar's Si	gnature	1100	B)	ULT 1117 121	re, MD	212		

Funeral Director filed within 72 hours after death with the Maryland r then "naturel", or items 23s or 28s-f ehow the Medical Examinar must be notified at Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed w
Department of Heelth and Mental Hygies
Important: if item 27 is marked other ti
eny injury or other treumatic event, ID
once.

/Medical Examiner attending physicien and for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by this After t death. Director:

Physician

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death r 18, 2006 3:30A. Physician September Krapf /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept. 14, 1917 5. Social Security Number 9. Birthplace (State or Foreign 1 □ M 2√2 F North Carolina 244-10-6797 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Prince George's Maryland Hyattsville 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3404 Chatham Road 20783 United States Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No White Specify. δ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Horace D. Breece Delia Louise Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Carl Stebbing -son 2410 2nd Street, E. Leigh Acres, Florida 33972 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 9/21/2006 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Bor wardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 L 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary arrest Due to (or as a consequence of): Hemorrhagic Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hypertension Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ANo Month Day Year 4□ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Xunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death | Check only one examiner Hospital: 1 🂢 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Injury 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check on one) 29b. Signature title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 19, 2006 D56147 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasreen Kango, M.D. 7610 Carroll Avenue, #205 Takoma Park, Maryland 20912 31. Date filed (Month, Day, Year) SEP 2 32. Registrar's Signature State

Registrar

within 24 hours e To the Funerel [

2 0 2006

parte

State of Maryland / Department of Health and Mental Hygien 2006 31507 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 1.15AM Bernice Agnes Kraker 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 T F Yrs. Director 501-22-2657 1929 77 July 24, North Dakota Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or Iteme 23a or 28a-f show 1 ☐ Yes 2€ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9800 McMillan Avenue 20910 USA permit. Pages 1 and 2 should be filed within 72 hours efter death a Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Iteme 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, It a Madical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse N.I.H./Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Math J. Kraker Elizabeth Theisen ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Tichich/ Niece 6724 Edgewood Drive Northwest, Albuquerque, NM 87107 itam 27 l 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State injury 1 Durial 2 ☐ Cremation 3 ☐ Removal from State Sept. 20, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 2006 21. Signatifie of Funeral Service Ligensee any in Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, nu MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Chronic obstructive primonory discore /Medical Examiner espiratore Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Pokemi that initiated events resulting in death) Last Box 68760. Physician/Medical *IF FEMALE* 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown page 2 should be detact Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 Yes 1 Yes 2 No Hospitel or Attending Physicien: After this certification, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending death. investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours efter within 24 hours of To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D 63439 18/06 M·D completed cause of death (Item 23a) (Type, Print) , KUSUMA KALYKWI 30. Name and address of person wh Candlavenue, Takoma Pank Maryland 7600, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 2 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sept. Day 15, 2006 Mary Kalinowski 1:16 p. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 174-16-2231 86 Director Yrs. 1920 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 21 No Directo Maryland Davidsonville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21035 United States 2795 Spring Lakes Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7/ h and Mental Hygiene. 7 ie marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Line Worker Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Arendas Julia Celegi 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Depertment of Health and Importent: If Itam 27 ie m eny injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Iagulli 2795 Springs Lake Dr. Davidsonville, MD. 21035 (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) September 16, Metropolitan Crematory Alexandria, Virginia 2006 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Advent Funeral & Cremation Service M00982 42 Hudson St. Suite 110, Annapolis, Maryland 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** atheroscleronc /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month signed by the aid be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably should peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy performed? (es 28 No certificete 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient ဥ 1 | Yes 2 No 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeret Director: After thi
completely filled in by the funeral. 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation Injury 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, address of person who completed cause of death (Item 23a) (Type, Print) 7 31. Date filed (Month, Registrar's Signature State Registrar

			For State Registrar	State o	f Marylan	d / Depa	artment o	f Health of Death	and M	R	leg. No. 4	1 1 1 1 1 1	31509
H	Physici	an	1. Decedent's Name (First, Middle, Alphee Maurice			т.	omos?			2. Date of Dea Month Septemb	th Day	3 300	3. Time of Death 5 12:20P.M
Y	/Medio		4a. Facility Name (If not institution,		mber)	ابلا	emay 4b. City, Tow	n, or Location		Septemo		ounty of Deal	
	LAGIIIII	CI	3122 Gracefield		05			er Spr			1	ontgom	ery
Non	Funeral Director		5. Social Security Number 003-03-5746 Usual Residence of Decedent	6. Sex 1	7. Age (In yrs.	7 Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Birth (Month, Day Feb. 10	, 1919	9. Bird Co New	hplace (State or Foreign buntry) Hampshire
	ehow	٥٢	10a. State 10b. County Maryland Montgo	mery		y, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28a-f	rect	10e. Street and Number	-			10f. Zip Coo	e			10g. Citize	n of What Co	ountry?
	ath with	ralD	3122 Gracefield	•				20904				ed Sta	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Hygiene dether than "natural", or iteme 23a or 28a-f ehow other than "natural", or iteme 23a or 28a-f ehow event, The Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	ed 1/X Yes	edent Ever in U prces? 2 No ve vates: 1951-1		Was Decedent If Yes, specify 0 1 ☐ Yes 2X			cify Yes or No- Rican, etc.)		. Race - Ame Black, Whit oec <i>ify:</i>	
r Š	72 hou nature	eted	15. Decedent' (Specify only highest	s Education		(Give	dent's Usual Od kind of work do	ne durina mo	st of workii	ng	16b. Kind	of Business	Industry
9200-91212	within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	life.	nt Offi	tired)			Unit	od Sta	ites ARMY
מ	Hygie other	e Co	17. Father's Name (First, Middle, L		<u></u>	Walle	inc Offi		er's Name	(First, Middle,			ites All'II
yiar	should be ind Mental marked c	To Be	Frank		I	emay			emire				Ferland
Maryland	0 0 = 4	9	19a. Informant's Name/Relationsh Elvira T. Lemay			2 .				Route Numbe	-		Zip Code) Mary land 209
	is 1 end in Health Item 27 other tr		20a, Method of Disposition			Place of Dispo	sition (Name or natory or other	1		ate		tion - City or	
Baltimore,	Pages ment of ant: If it		1 ☐ Burial 2 ⚠ Cremation 4 ☐ Donation 5 ☐ Other (Sp			ropoli	tan Cre	matory					Virginia
Pai	permit. Pages Depertment of h Important: If its eny injury or of		21. Signature of Funeral Service L	Sageva	af	Ď 4.	onald V 400 Pow	der Mi	wardt 11 Ro	Funera ad Belt	1 Hon svill	ne, PA Le, Man	ryland 20705
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on e	aused the deat each line. Cute My					r respiratory ari	rest,		Approximate Interval Between Onset and Death minutes
	/Medical		disease or condition resulting in death)	Due to	(or as a conseq	uence of):							minuces
	Examiner	_	Sequentially list conditions,	D	therosc		c Coror	ary Ar	tery	Disease	€		years
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	lyperter								
8/60,	certificate be executed nding physicien and use as the burial-transit		resulting in death) Last		or as a consequence of the conse		olemia						
Õ	eath certifica ettending ph for use as th	/Med	IF FEMALE:	230 If was our	tcome of pregna	2004							
P.O. Box	death e etter d for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live t	oirth 2 🗌 Feta nant at time of c	Ideath 3	Ectopic pregna Other (specify				23	d. Date of de Month	rvery Day Year
	as the	d by Pr	Part II. Other significant condition Aortic Stenosis	ns contributing to d	eath but not res	ulting in the u	nderlying cause	given in Part	l.		bacco use		o the cause of death? robably 4 □Unknown
Vital Records,	0 4 0	Completed by								24a. Was a autop perfor		24b. Were at prior to death?	utopsy findings available completion of cause of
IIa	ician: Th certificate ector, pag	BeC	25. Was case referred to medical examiner?						e of Death	(Check only or		10103	
5	Physic this corral dire	ဥ	1 ☐ Yes 2 ☐ No 27. Manner of Death			ER/Outpatier	1 3 DOA			ne 5 Resid			cify)
0	Attending Physician: If death. Cotor: After this certific by the funeral director.	atlon	1 ∠Natural 5 Pending 2 Accident investig		of Injury th, Day Year)	Injury		njury at Work? 1 □ Yes 2 □			Ow inquiry (occarred	
Division of	el or Attende de d	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	of Injury - At he ing, etc. (Specil	ome, farm, str	eet, factory, off	се		28f. Location (5 City or Tow		Number or R	ural Route Number,
	To the Hospitel or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E	g Physician: To the Examiner: On the b and man	e best of my kno easis of examina ener stated.	owledge, death	h occurred at th vestigation, in n	e time, date a ny opinion, de	nd place, a	and due to the dead at the time, o	ause(s) ar	nd manner as lace, and due	s stated. to the cause(s)
	To th within To th	Me	29b. Signature and little of certifier				l l	ense number		4		_	h, Day, Year)
1	140		107/-	red				590			Sep	otember	19, 2006
			Roy Fried, M.D	•	3110 G	racefi	eld Roa	d Silve	er Sp	ring, M	aryla	and 209	904
10	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 0	2006	Registrar's Signa	ture /	W.						

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Division of Vital Records, P.O. Box 68760,	õ
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	the Hospital or Attending Physicien: The law requires that the death certificate

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	4	For State		State of Ma	aryland		epartment of H Dertificate of I			2000	31510
1.87		Stata Registrar	e (First, Middle, Last,)			erincale of i	Dealli	2. Date of Death	g. No. h	3. Time of Death
Physician /Medical	10		BETH C. LI						Sept	OG SCO	
Examine		1	f not institution, give	1 1			4b. City, Town, or	Location of Death	,	4c. County of Dea	Ę
*			umber 6. Se.	Hosp	e (In yrs. las	t hirth	(av) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Bir	thplace (State or Foreign
Funeral Director		5. Social Security N 220-66-6 Usual Residence of	705	M 20 X F	52	Yr	Months Days	Hours Min.	AUG 13	Year) Co	LIFORNIA
and III	-	10a. State	10b. County		10c. City,	Town	or Location				10d. Inside City Limits
r 28a-f show	2	MD	TALBOT			T	LGHMAN				1XYes 2□No
death with the Maryland ms 23e or 28e-f show rittual be notified at	<u> </u>	10e. Street and Nu	mber				10f. Zip Code		10	0g. Citizen of What C	ountry?
23a c	2	21431 W	. COOPERT				2167		- / V N	USA 14. Race - Am	riana la dina
or Items 23a or	2	11. Marital Status	ind 2007 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🟋		İ	 Was Decedent of H If Yes, specify Cuba 	an, Mexican, Puerto	Rican, etc.)	Black, Whi	
hours after tural; or ite	2	3 Widowed	ied 2 ∑ Marned 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🙀 No	Specify:			HITE
permit. Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "natural; any injury or other treumatic event, tra Madical Exa	Completed		15. Decedent's Educity only highest grad	le completed)	5.1	6	Decedent's Usual Occup Give kind of work done life. DO NOT use retired	during most of work		16b. Kind of Business	/Industry
filed within 72 Hygiene. Ither then "natent, the Medic	Eo	Elementary/Second 12	ondary (0-12)	College (1-4or	5+)		ASSISTANT	MANAGER		SPECIALTY	STORE
al Hyg	ae C		(First, Middle, Last)					18. Mother's Nam			
should be ind Mental marked our	0	JOHN MI	LLS COCKE	Y					E WATSON		7
2 shd and le m			ame/Relationship (T			19b. i	Mailing Address (Street				
1 and Health em 27 ther tr	-	NEAL LE 20a, Method of Dis	DNUM/HUSB	AND			21431 W. C	1		20c. Location - City o	
Pages nent of I ant: If Itu ary or o'		1 🗆 Burial 2	X Cremation 3 □ I				, crematory or other place		/8/2006	STEVENSVI	LLE. MD
artme artme ortani injury	+		5 Other (Specify, uneral Service Licens		CHE)AI I	22. Name and Addre	ss of Facility	-		
permit. Departe Import. any inj		Josey) . ce yo	Istrouh.	c.F.S/-)	FELLOWS,	HELFENBEI	N & NEWN	NAM FUNERA MD 21601	L HOME PA
Physician /Medical Examiner	Examiner	shock, or head in manadiate Cause disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter Und Cause (Disease or that initiated event resulting in death)	onditions. onditions. onditions. original onditions. originary originary originary	b. Due to (or as	s a conseque	ence of		1 .			Interval Between Onset and Death
0	Physician/Medical E	IF FEMALE: 23b. Was deceded in the past 12 1 □ Yes 2 9 □ Unknow.	nt pregnant 2 months? No	d	2 Fetal	death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of di Month	alivery Day Year
s that the	by Ph			ontributing to death	but not resul	ting in	the underlying cause gr	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
w requires been sig should b									1 🗆 Yı	es 2 No 3 F	robably 4 Dirknown
The law re ate has be page 2 shr	Completed								24a. Was a autops perform	med? prior to death?	autopsy findings available completion of cause of
cien: ertific actor,	Be (25. Was case rete	erred to medical	()ii			r ! ou	hon	th Check only or		
ding Physicien: The law h. After this certificate has funeral director, page 2	tion: To	1 Tyes 2		Hospital: 1 ☐ Inpat 28a. Date of Inj (Month, D		28b. T	ime of jury 28c. Inju			ence 6 Other (Sp ow injury occurred	ecify)
	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not be	28e. Place of Ir	njury - At hor atc. (Specify	ne, far	m, street, factory, office		28f. Location (S City or Tow	treet and Number or i n, State)	Rural Route Number,
the Hospital or hin 24 hours afte the Funerel Dir mpletely filled in	edicai C	29a. Certifier (Check only one)	1 Certifying Ph 2 Madical Exam	ysician: To the bes niner: On the basis and manner s	of examinati	viedge, on and	, death occurred at the to for investigation, in my	ime, date and place opinion, death occu	, and due to the d rred at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
To th within To th comp	Me	29b. Signature an	d title of certifier				29c. Licen	se number	4	29d. Date signed (Mo	nth, Day, Year)
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					S. WA		NGTON ST EA	ASTON, MD	21601		
Stat Registra		31. Date filed (Mo	P 1 1 200		0 1		Solo				

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Waverly Corey Lewis 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ WAVERLY COREY LEWIS 1352 hrs Medical Examiner September 14, 2006 4c. County of Death 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1329 Gold Meadow Way Apartment 203 Harford Edgewood 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** oreian Months Days Hours Director 03/29/1987 082-72-6763 19 Country)NEW YORK 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County MARYLAND HARFORD **EDGEWOOD** 1 X Yes 2 No 23a or 28a-f show notified at once. hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1329 GOLD MEADOW WAY 21040 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 X Never Married 2 X No Yes BLACK 3 Widowed 4 Divorced If Yes. Give Year 1 Yes 2 X No specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) t. Pages 1 and 2 should be filed within 72 thent of Health and Mental Hygiene. Baltimore, MD 21215-0036 CONSTRUCTION BUILDING 10 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last marked Be WAVERLY TONY LEWIS THERESA GOODSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THERESA LEWIS / MOTHER item 27 is 1327 GOLD MEADOW WAY, EDGEWOOD, MARYLAND 21040 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 X Removal from State ROSEDALE CEMETERY 09/26/2006 mportant: LINDEN, NEW JERSEY 4 Donation 5 Other Specify: 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, 21. Signature of Funeral Service Licenses MD 21078 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions.

The law requires that the death certificate be executed and signed by the attending physician a be detached for use as the burial Box 68760, Division of Vital Records, P.O. certificate has the Hospital or Attending Physician: hin 24 hours after death. After this

Examine Physician/Medical ð Completed Be Certification: within 24 hours after death To the Funeral Director: the

Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth past 12 months? Pregnant at time of 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

> 26.Place of Death (Check only one) Inpatient ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury FOUND: Sep 14, 2006 1341 hrs

2

5

28c. Injury at Work? Yes 2 V No 28e. Place of Injury - At home, farm, street, factory, office building, etc

29c. License number

Other:

3 Ectopic pregnancy

28d. Describe how injury occurred Subject shot 28f. Location (Street and Number or Rural Route Number, City or Town. State!

Residence 6 V Other: Scene

24a Was an

✓ Yes 2

Nursing Home 5

autonsy

performed?

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

Yes 2 ✓ No 3 Probably 4 Unknown

1 🗸 Yes

29d, Date signed (Month, Day, Year)

September 15, 2006

24b. Were autopsy findings available prior to completion of cause of

Year

2 No

1329 Gold Meadow Way, Edgewood, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

and manner stated

31. Date filed (Month, Pay 2006

25. Was case referred to medical

29b Signature and title of certifie

No

Pending

Investigation

Could not be

determined

examiner?

2

3

Medical

State

Registra

1 V Yes

27. Manner of Death

Natural

Accident

Suicide

4 V Homicide 29a. Certifier

32. Registrar's Signature

(Specify) Multi-Family Apt.

Fetal death

Other (Specify)

			For State	State of M	aryland / Der	partment of Hertificate of L		lental Hygie	ne 2006	31512
			1 - State Registrar	-1		ertificate of L	Jeain	Reg. 2. Date of Death	NE UUU	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Las	1				Month	Day Year	7.115 74
	/Medic		Jolene MacDong			# 65 T		Septembe	4c. County of Dea	
7	Examin	er	4a. Facility Name (If not institution, give		of Center		Location of Death	201		
			5. Social Security Number 6. Se		ge (In yrs. last birthda		If Under 24 Hrs.			ore City
	Funeral			_M 28 F	53 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye		thplace (State or Foreign buntry)
	Director		Usual Residence of Decedent					07/14/19	55 Per	nnsylvania
	yland Now		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Man	to	MD Cecil		North H	last				1∭ Yes 2 No
	r 28s	rec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	h wit	Funeral Director	61 Sycamore D	rive		21903	1		USA	
	dea m	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13	. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spendan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	after or its	F	1 Never Married 2 Married	1 ☐ Yes 2 ☑ If Yes, Give		1 ☐ Yes 2 No	Specify:	,,	Specify:	10, 5151
8	hours after death with the Maryland turel', or iteme 23a or 28a-f ehow al Exeminer must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:			150 1			White
5-	72 "na	Completed	15. Decedent's Ed (Specify only highest grad		(Gi	edent's Usual Occupa re kind of work done of DO NOT use retired	during most of worki	ing 16t	o. Kind of Business	/Industry
12	within 72 ene. then "nai	Ę	Elementary/Secondary (0-12)	College (1-4or	5+)				Healthcan	re
22	Hygie Hygie ther		17. Father's Name (First, Middle, Last)		Nur	sing Assi		e (First, Middle, Mai		
an	should be filed withir ad Mental Hygiene. marked other then umatic event, the Market and the Market the Market and Market the Market and Market	Be								
2	should ind Men ind Men in marke	٩	Ronald L. Leon 19a. Informant's Name/Relationship (7)		19b. Ma	iling Address (Street a	Mary P		ity or Town, State,	Zip Code)
Maryland 21215-0036	d 2 sho th and t7 te my treum	1 1	John N. MacDouga			Sycamore 1		orth East		
	s 1 and 2 should if Health and Men teem 27 te marke other treumatic		20a. Method of Disposition	i / nusba	20b. Place of Dis	position (Name of			. Location - City or	
Ö	8°= 5		1 Burial 2 Cremation 3 ☐ 4 Donation 5 Other (Specify			ematory or other plac		0 /0006		ru 10223
Baltimore,			21. Signature of Fugeral Service/Qcen		Falryie	w Cemeters 22. Name and Addres		2/2006 C	oatesvil	Khmak on
Ba	permit. Depertr Imports eny inj		Februar 2	Prom. D	200393	Stranhi	Loolpy I	Judaral 4	NEWACK	Children 16
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	lications that cause	d the death. Do not e	inter the mode of dyin	g, such as cardiac	or respiratory arrest	10001317	Approximate
		1	shock, or heart failure. List only of Immediate Cause (Final	- 1						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Endocara	a consequence of):					1 MENTY
	Examiner				sufficiency					Imanth
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injusted events.)	U	a consequence of	7				
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	5epsis						month
oʻ	te be executed ysicien and e burial-transit		resulting in death) Last	D e to (or as	s a consequence of):					
760,	# × 6	cai		d						
68	The law requires that the death certification is the beson signed by the ettending phy bage 2 should be detached for use as the	Med	IS SENALS							
Вох	th cer endir r use	and a	230. Was decedent pregnant	23c. If yes, outcome		B DEctopic pregnancy	,		23d. Date of de	•
	e dea	SICE	in the past 12 months? 1 ☐ Yes 2 No			Other (specify)			Month	Day Year
P.0	that the de led by the e detached f	Physician/Med	9 ☐ Unknowń							
	es th ignec be d	ğ	Part II. Other significant conditions of	ontributing to death	but not resulting in the	underlying cause givi	en in Part I.			to the cause of death?
5 d	w requir been si should	ted	Martial Obesity					1 Yes	2 □ No 3 □ P	robably 4 🔁 Unknown
of Vital Records,	hesby	Completed	J					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u> </u>	The zate h page	5						performer	d? death? No 1 ☐ Ye	
/ita	Physician: The this certificate hural director, page	Be	25. Was case referred to medical examiner?			Tai		h (Check only one)		
=	Physic this c	P	1 ☐ Yes 2 No	Hospital: 1 Depat			4 Nursing Ho	me 5 Residence		ecify)
Ĕ	D = 0	Certification:	27. Manner of Death 1 Solatural 5 □ Pending	28a. Date of Inj (Month, D	ury 28b. Time ay Year) lnjur	Worl		28d. Describe how	injury occurred	
Si Si	Attending in deeth.	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2□No	ORA I service (Char	at and Atomber on F	Trans Claude Alumbas
Division	or At	III	4 Homicide determined	286. Place of it	njury - At home, farm, etc. (Specify)	street, factory, office		City or Town, S		Rural Route Number,
	To the Hospital or Attendii within 24 hours after deeth. To the Funeral Director: A completely filled in by the fu	ပ္	29a. Certifier 1⊠ Certifying Ph	vsicien: To the har-	t of my knowledge, de	ath occurred at the time	ne date and place	and due to the accor	sole) and manner a	s stated
	Hos 24 ho Fun stely	Medicai			of examination and/or					
	o the o the omple	Me	29b. Signature and title of certifier			29c. Licens	e number	29d	. Date signed (Mon	nth, Day, Year)
	⊬ 3 F δ		Som	Amus	sturys	167	81	8	eptender 2	2006
			30. Name and address of person who	completed course of	death (Item 23a) (Tim	e Print)	`		1	
	5		Anystumo White	VSTON OF M	auful He	dien center	225.9	reene 8t	Baltimore	MD 21201
	St	ate	31. Dale filed (Month, Day, Year)	32. Reg	trar's Signature	1.0.	· · · · · ·			
	Regist		SÉP21	2006	death (Item 23a) (Typer Manufaux Manufa	apare				

		State of Maryland / Department of Health and Months 1- State Registrar	ental Hygie Reg	2000 31313
			2. Date of Death	3. Time of Death
Physici /Medic		Lyale Harry Ostrander	SEPTEMBER	Day Year 8:55 AM
Examin		4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death		4c. County of Death
	ш	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	9. Date of Righ	9. Birthplace (State or Foreign
Funeral Director		393-22-1508 1 Months Days Hours Min. 1 Months Days Hours Min.	8. Date of Birth Month, Day, Y 12/10/19	ear) Country) Wisconsin
9		Usual Residence of Decedent		
arylar	J.	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 H Yes 2 □ No
the M	Director	MD Harford Aberdeen 10e. Street and Number 10f. Zip Code	100	. Citizen of What Country?
3a or		69 Dixon Avenue 21001		U.S.A.
Geath Geath	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	14. Race - American Indian, Black, White, etc.
STRANDER 1215-0036 within 72 hours after death with the Maryland ene. than "natural; or items 23e or 28e-1 show its Marylen and its market indifficult at the modified at	y Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No WWTT - 1 □ Yes 2 □ No Secritive	noun, oto.;	Specify: White
215-0036 thin 72 hours ale an "netural; or Mudical Extra	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: KOYE ā ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	16	b. Kind of Business/Industry
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tind be file of oth of oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name		iden Sumame)
Maryland 2 d 2 should be filed the marked other traumatic event, I	ပ္	Claude Ostrander Hilde Ho 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural		Titu or Town State Zin Code)
and 2 s sealth an n 27 is ner traus		Ronnie L. Ostrander (son) 110 Chatsworth Circ		
DEF H, OSTRANDER Nore, Maryland 21215-0036 198s 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 is marked other than "natural; or itema 23s or 28e-1 show or other traumatic event, the Medical Exactinatic and be notified at		20a. Method of Disposition 20b. Place of Disposition (Name of Dispositio		c. Location - City or Town, State
YALE altimore mii. Pages 1 parimoni of He portent: if ther y injury or oth		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) R.A. Ferris & Co.Inc. 09/25	5/2006 W.	Chester, PA
Explain to the traumatic event, ITAME The Control Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importents: If item 27 is marked other than any highry or other traumatic event, ITAME ODGE.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring—Cargo Fune 333 S. Parke St.,	eral Home	P.A.
		3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or		. Approximate
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	luce 1	Interval Between Onset and Death
/Medical Examiner		resulting in death) Due to for as a consequence of):	Jure 1	0 1.1110
LAAIIIIIei	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
101/ B B	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
0, 9 exec	Еха	resulting in death) Last Due to (or as a consequence of):		
18760, cate be execued physician and the burial-transit	dicai	d		
Box 6		IF FEMALE: 23c. If yes, outcome of pregnancy		22d Date of delivery
Box death cerr	iclan/Me	23b. Was decement pregnant in the past 12 months? 1 \[\text{Live birth} \] 2 \[\text{Fetal death} \] 3 \[\text{Ectopic pregnancy} \] 1 \[\text{Vos } 2 \] No \[\text{No.} \] 4 \[\text{Pregnant at time of death} \] 5 \[\text{Other (specify)} \]		23d. Date of delivery Month Day Year
P.O. I	Physi	9 Unknown		
of Vital Records, P.O. Box 6 Physician: The law requires that the death certificate has been signed by the attending rall director, page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	2 DNo 3 Probably 4 Unknown
Division of Vital Records, to Attending Physician: The law requires tather death. Director: After this certificate has been signed in by the funeral director, page 2 should be	ompleted		24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Re(The lav te has	отр		autopsy performe 1 ☐ Yes 2 ☑	d? death?
f Vital Roysiclan: The sentificate hadirector, page	Be C	25. Was case referred to predical examiner?		100 100 2120
of V Physic this ce	To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4, Wrsing Hom		ee 6 Other (Specify)
In grant	lon:	1 Natural 5 Pending (Month, Day Year) Injury Work?	8d. Describe how	injury occurred
risic Attend death ctor: y the	ertification	Z Accident	8f. Location (Stree	et and Number or Rural Route Number,
Div al or A	Serti	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, S	
Division To the Hospital or Attending with: 24 hours after death. To the Funeral Director: After completely filled ir by the funeral completely filled in the funeral c	dical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, at 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the caused at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
To the within To the Country on the	M	29b. Signature and title of certifier 29c. License number	29d	. Date signed (Month, Day, Year)
		Manuel DIGTES		September 23,200
		30. Name and address of person who completed cause ondeath (Item 23a) (Type, Print)	ret.	
		31. Date filed (Month, Day, Year) 32. Redistrar's Signature.	n, yo	my (and 400)
Sta Registi		SEP 2 5 2005	, ,	,

State of Maryland / Department of Health and Mental Hygiene 006 31514 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sept. 19, 2006 Rosalie Betty O'Connor 2:30 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mallard Bay Care Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth April 21, 1949 9. Birthplace (State Month) Mary Land 9. Birthplace (State or Foreign Funeral 1□M 2MF 215-52-3501 57 Yrs. Director Usual Residence of Decedent 10b Counts 10c. City, Town or Location 10a State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene.

Department of Health and Mantal Hygiene.

The Maryla Hygiene is a state of the state of t Maryland 1 res 2 No Cecil Director Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 48 Oakridge Court 21921 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 MDivorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Klunk Catherine (maiden name unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cory C. O'Connor/Son 35 Wenark Dr., Apt. 12, Newark, DE 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) All Saints Cemetery 09/25/2006 Wilmin ton DE 2 Signature of Funeral Service Licensee Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Antireopel **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed anding physicien end use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) certificate hes been signed by the intector, page 2 should be detached? 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1□ Yes 2□No nerei Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Horrucide To the Hospital within 24 hours at To the Funerel Completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D63359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUGORA ST. Cambridge, MD-21613 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 2 1 2006 >

, e 2	- FOI	partment of Health and Mertificate of Death	Reg. 2 0 0	6 3 1 5 1 5
Physician /Medical	Mary Alice Phillips		Sept. 17, 2006	8:15 a M
Examiner	4a. Facility Neme (If not institution, give street and number) Chesapeake Woods Center	4b. City, Town, or Location of Death Cambridge		Death hester
Funeral Director	5. Social Security Number 220-01-3722 6. Sex 1 M 2 F 84 Yrs	Months Days Hours Min	8. Date of Birth Jane, Day, Year 922	Birthplace (State or Foreign Marry Land
within 72 hours after death with the Maryland ane. The man natural; or items 23a or 28e-1 show he Madical Examinar must be notified at morpheted by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Dorchester C	Location ambridge		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
23s or 28e ust be notifi ral Direct	10e. Street and Number 114 Sandy Hill Road	10f. Zip Code 21613	10g. Citizen of Wh	at Country?
ai, or items 23a or 28e-fe Examinat must be notified by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Green Year or Dates:	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 Mo Specify:	ecify Yes or No- Rican, etc.) 14. Race- Black, Specify:	American Indian, White, etc. White
ygiene. ner than "natural" it, the Madical Ex. Completed b	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work a. DO NOT use retired)		
ental Hygic ked other ic event, II	11 17. Father's Name (First, Middle, Last) Leslie Hurley	Homemaker 18. Mother's Name	Ow e (First, Middle, Maiden Surname) Ethel Hurley	n Home
h ar	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address <i>(Street and Number or Run</i> 6 Sandy Hill Rd., (ate, Zip Code) 1613
ent of Health nt: if item 27 ry or other tra		sposition (Name of trematory or other place) rans Cemetery 09/1	Date 20c. Location - Ci	
Department of Importent: If it end in it is it is in it i	21 Signature of Funeral Service License	22 Name and Address of Facility Fur 308 High St., Cambr	neral Home, P.A.	
to death. The law requires that the death conflicate be executed to death. The death. The death control of the	23a Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	enter the mode of dying, such as cardiac of the mode of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of the mode of dying, such as cardiac of the mode of the	or respiratory arrest,	Approximate Interval Between Onset and Death
by the attending phy tached for use as the thysician/Medi		3 Ectopic pregnancy 5 Other (specify)	23d. Date of Month	The second secon
certificate has been signed by the attending phyrector, pege 2 should be detached for use as the BE Completed by Physician/Medi	Part II. Other significant conditions contributing to death but not resulting in the Hyper tension Pulmon a Osliteo arthr. + (5, Type III) ementia and IIII	DiAbetes,	24a. Was an autopsy performed?	ute to the cause of death? Probably 4 Unknown ere autopsy findings available for to completion of cause of ath? Yes 2 No
anding Proystotant. asth. or: After this certific he funeral director. cation: To Be (examiner? 1	tient 3 DOA Other: 4 Hursing Ho	me 5 Residence 6 Other 28d. Describe how injury occurred	
Hospitel of Attending Presented and the teneral Director: After telly filled in by the tuneral lical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street and Number City or Town, State)	
To the Hospitel or Attendi within 24 house after death. To the Funeral Director: A completely filled in by the ti	29a. Certifier Check only (Check only one) 29b. Signature and title of certifier Certifying Physician: To the best of my knowledge, do not not not not not not not not not no	eath occurred at the time, date and place, investigation, in my opinion, death occurred.	and due to the cause(s) and manned at the time, date and place, and	d due to the cause(s)
	30. Name and address of person who completed cause of death (Item 23a) (Ty	10. H 446 De, Print) RC W	5 00	heid on
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	had .	- (Am)	S. Ogernia

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 116 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2006 6:35P August 26 Naomi Pack /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Marley Neck Health & Rehab Glen Burnie 7. Age (In yrs. last birthday) If Under Months If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July 26 1928 Maryland Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 25 F 78 Yrs. 219-32-2009 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 28a-f show The Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 21122 USA 8059 Crovdon Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, or Items 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Black Specify: Specify: ģ 3 XWidowed 4 □ Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ns any injury or other traumatic event. If a Mudit once. (Specify only highest grade completed) Callege (1-4or 5+) Elementary/Secondary (0-12) Anne Arundel Co. Home Health Aid 12th 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Jennings Edward Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8059 Croydon Way Pasadena, Md. 21122 Sheila Walton(Daughter) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 9-1-06 Severna Park, Md. Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. Lavry Sd. Tees Mc6 18 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ardiac lamia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner inding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atten Id be detached for u Day Year Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 10 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown plnods Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 □ N or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes ₽ No 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospite. within 24 hours after death.
To the Funeral Director: After this c 1 Inpatient 2 ER/Outpatient 3 DOA 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Contriguing Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature ar title of certifier and addr. of person who completed cause of death (Hem 3a) (Type, Print) 600K Vi 31. Date filed (Month, Day, Year)

AUG 3 0 2006 . Registrar's Signature (State Registrar

		_	- State END#130=rFH9/28/06	State of Maryland	d / Dena	artment o	f Health a	nd Mental Hy	/giene2006	31517
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Teresa Morales Ro					2. Date of D Month Septer	nber18,2006	3. Time of Death 3:00A. M
	Examin		4a. Facility Nam Gondom ution, give st 12000 Gordan Avenue	reet and number)		4b. City, Tow Be	n, or Location of ltsville	Death	4c. County of De Princ	e George's
	Funeral Director		074-34-3716	7. Age (In yrs. It		If Under 1 Y Months Da		Min. B. Date of B. (Month, D. Janua)	9. B ry5,1916 Pu	irthplace (State or Foreign Country) erto Rico
	ehow	J.	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geo		tsvill					10d. Inside City Limits 1 ☐ Yes 2 ▼No
	with the M a or 28e-f be notifi	Direct	10e. Street and Number 12000 Gordon Avenue			10f. Zip Co			10g. Citizen of What C	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28e-f ehow important: if Item 27 is marked other then "natural", or Items 23a or 28e-f ehow enjoying or other traumatic event, the Madical Examinar must be notified a page.	by Funeral Director		2. Was Decedent Ever in U.S Armed Forces? 1	1	Was Decedent f Yes, specify	ol Hispanic Orig Cuban, Mexican, P No Specify:	in? (Specify Yes or N Puerto Rican, etc.)	Black, Wh	nerican Indian, lite, etc. White
215-00	ithin 72 hour ie. ien "natural i Madisal E.	Completed t	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give life.	DO NOT use re	one during most	of working	16b. Kind of Busines	·
Maryland 21215-0036	ild be filed w fental Hygier rked other th lic event, the	To Be Cor	17. Father's Name (First, Middle, Last) Francisco Morales		Homen	aker		's Name <i>(First, Middl</i> .a Rivera	OWN hom le, Maiden Sumame)	e
Mary	nd 2 shouth and N		19a. Informant's Name/Relationship (Type Sonia R. Kirk -daug			•			ber, City or Town, State le, Marylan	
ore,	or other		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Re	20b. P		osition (Name of matory or other		Date 7 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2	20c. Location - City of	r Town, State ring, Marylan
Baltimore,	permit. Pa Departmer important eny inlury once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Donald U. 13		Ě	onatu ^	ddressBor Facility	ardt Fune	ral Home, P	
760,	Physician /Medical Examiner	ilcal Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one limmediate Cause (Final disease or condition resulting in death) S. uentiely list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or rigury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of): ni A uence of):			AILVRE		Iniferval Between Onset and Death
.O. Box 68	that the death certificate bed by the ettending physic detached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🖾 No 9 □ Unknown	tc. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do 9 Unknown	Ideath 3	□Ectopic pregr □ Other (specifi			23d. Date of o Month	delivery Day Year
<u>α</u>	uires that n signed b ild be deta	by	Part II. Other significant conditions con	tributing to death but not rest	ulting in the u	inderlying caus	e given in Part I.		tobacco use contribute]Yes 2□No 3□	to the cause of death? Probably 4 \textstyle Unknown
of Vital Records,	. The law requires that the sate has been signed by the page 2 should be detache	Completed						per	topsy prior t formed? death	autopsy findings available o completion of cause of ? es 2□ No
Vita	Physician: this certific ral director,	o Be	25. Was case relerred to medical examiner?	ospital:	ER/Outpatie	nt 3 DOA	Other	ol Death <i>Check only</i>	rone sidence 6 □Other (S	pecify)
on of	ling After Tune	 -	27. Manner of Death 12 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Injury at Work? 1 Yes 2 1	28d. Describ	e how injury occurred	
Division	al or Atteriors after dealth	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, larm, st	reet, factory, o	fice		(Street and Number or own, State)	Rural Route Number,
	ne Hospital or na 24 hours after ne Funerel Dire	Medical	29a. Certifier 1 ACertifying Physics (Check only one) 2 Medical Examin	ician: To the best of my knower: On the basis of examina and manner stated.	wledge, deat tion and/or in	th occurred at to evestigation, in	he lime, date and my opinion, deat	d place, and due to the h occurred at the time	e cause(s) and manner e, date and place, and c	as stated. lue to the cause(s)
	To the Hosp within 24 ho To the Func completely fi	Ň	29b. Signature and late of certifier	Hier			cense number 53235		29d. Date signed (Mo September	
	1		30. Name and address of person to co Darryl Anthony Hi	mpleted cause of death (Item 11, M.D. 1363	n 23a) (Туре 5 Balt	Print)	Avenue	Ma Laurel, M	aryland aryalnd 207	05
	St Regist	ate	31. Date liled (Month, Day, Year) SEP 2 0 2006	2. Registrar's Signa	Store	di)				

State of Maryland / Department of Health and Mental Hygiene 2006 31518 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Rideout 2006 1729 06 Jennis 2001 ambon /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner l Hospita Dorchester orchaster mbr enerch If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Months Hours 72 Director Maryland 214-32-0152 06-27-1934 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Vienna Maryland Dorchester Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21869 Items 23a Funeral 4840 Kraf Road USA deeth Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours after uent of Health and Mental Hygiene. Int: If tem 27 ia marked other than "natural", or Ite 1 Never Married 2 Married ☐Yes 2 No Yes, Give 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Black ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Dorchester Elementary/Secondary (0-12) College (1-4or 5+) 10 Heavy Equitment Operator County Roads other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Rideout Nonnie Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Williemina Rideout / Wife 4840 Kraft Road, Vienna Maryland 21869 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of H Important: If its any Injury or of 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Reids Grove Cemetery 09-12-2006 Reids Grove, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home ammie 516 S. Main Street, Hurlock, Maryland 21643 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septicemiz **Physician** /Medical Due to (or as a consequence of) **Examiner** Pheumous Sequentially list conditions, if any laborate to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consumuence of Examine Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Direse Brterioselevalic Hear -Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ac love 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 20 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 ER/Outpatient 3 DOA this : After this tuneral c 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 27. Manner of Death 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. ofter death Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 - Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAD 9-6-06 047924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THAN WY 21613 300 NURDANA CAMPRIDGE NOMAN 31. Date filed (Month, Day, Year) egistrar's Signati State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicia /Medic Examin	al
Funeral Director	

item 27 is marked other then "naturel", or Items 23a or 28a-f show other treumatic event, the Medical Examination ust by multired at permit Pages 1 and 2 should be file.
Department of Health and Mental Hygi.
Imporhent: filem 27 is marked any injury or other to a

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

hed by the attending physician and detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760 After this certific funeral director, s after de-ral Director: Att within 24 hours a

To the Funeral I

completely filled

Reg. No. 006 Certificate of Death 2. Date of Death Roberts Decedent's Name (First, Middle, Last) September De Day Ann 7:00 PM Anita 19, 2006 4c. County of Deeth 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Western Maryland Hospital Center
5. Social Security Number 6. Sex 7. A. Washington Hacerstown
If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1□M 2XF Months Days Hours Min. 218-02-1799 38 Yrs. DEC MD 6 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No WASHINGTON SMITHSBURG Director MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21783 USA 103 DREW CIRCLE Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: WHITE β 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS RESTAURANT 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANNA M. HAGAN GEORGE LEO ROBERTS, JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE ROBERTS, JR./FATHER 103 DREW CIRCLE, SMITHSBURG, MD 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) FREDERICK CREMATORY 9/21/06 FREDERICK, MD 21. Signature of Juneral Service Lio insee HILTON FUNERAL HOME 20838 BOX 86, BARNESVILLE, P.O. 238. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): thaxic ence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last stroke Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2**X** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) September 19, 2006 29c. License number 29b. Signature and title of certifier D44996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue DR. MALIK Hagerstown, MD 21742 31. Date filed (Month, Day, Year) 32. Registra's Signature State

DHMH 17 Rev 1/2001

Registrar

2 1 2006

amend items 1 24a 25/ per adore 860 Health and Mental Hygiene 0 0 6 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Ian Rogers Month **Physician** ロスマナ August 20010 Rhys /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner he Johns Shitmore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months, Days Hours Min. Month, Day, Year, Aug 8 1999 5. Social Security Number 9. Birthplace (State or Foreign Бөх 1**Х**М 2□ F Funeral 7 Yrs. Maryland 217-55-7986 Director Usuat Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "natural", or iteme 23a or 28e-f ehow the Medical Examinar must be notified at 1 Yes 2 No Hagerstown Washington Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21742 213 Stanford Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No ff Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other then any injury or other traumatic event Elementary/Secondary (0-12) Colfege (1-4or 5+) Student K 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jeff Rogers Heather Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Rogers (father) 213 Stanford Road Hagerstown Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Cemetery Sept 3 06 Smithsburg Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Pant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Crl. oblastoma 10 months. /Medical Due to (or as a consequence of): Examiner squanticly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) 68760, Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) o the detached 9 Unknown 9 Unknown δ Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ sign d be Seizure disorder 1 BYes 2 No 3 Probably 4 Unknown Completed page 2 should peed 24b. Were autopsy findings available prior to completion of cause of death? Hydrocephalus 24a. Was an has autopsy performed? certificete Central hypotensin 1 ☐ Yes 2 ☐ No 1 Yes 2X No of Vital : After this certifice e funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: Division To the Hospitel or Attending 5 Pending investigation 1 XNatural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281 Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 [A-Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00064681 August 31, 2006 MO

State Registrar

31. Date filed (Month, Day, Year)

Ran

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006

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	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day Year								
	/Medic	cal	Jerry Douglas Stroup 4a. Facility Name (If not institution, give street and number)	Sept.	19, 2006 9:45 A M									
1	Examin	ier	15605 Bounds Ave.	4b. City, Town, or Location Laure1	1 Of Death	Prince Georges								
	Funeral	III.	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	/ If Under 1 Year If Under	er 24 Hrs. 8. Date of Birt	h 9. Birthplace (State or Foreign								
	Director		216-52-6174 1♥M 2□F 57 Yrs.	Months Days Hours	Min. Sept.	^{y, Ygar)} , 1949 ^{Country)} MD								
	pura A		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits								
	f sho	ō	MD Prince Georges	Laurel		1 ☐ Yes 2 ☐ X o								
	7 28a-	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?								
	238 o	a D	15605 Bounds Ave.	20707		USA								
	ame ame	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica	Origin? (Specify Yes or No- an, Puerto Rican, etc.)	- 14. Race - American Indian, Black, White, etc.								
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ם	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)		her's Name (First, Middle,									
<u>ya</u>	Men narke	2	Ellis H. Stroup		Jean Borma									
Mai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23s or 28s-1 show any futury or other traumatic event, the Macical Examinar main be notified at ance.			7 Coventry		er, City or Town, State, Zip Code) etown, MD 21769								
ē,	Heali Heali tam 2	1 5	20a Method of Disposition 20b. Place of Dis	position (Name of	Date	20c. Location - City or Town, State								
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Baltimore,	mit. F partmy porter / injur			22 Name and Address of Fact Donald B. T										
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Baltimore,	permit. Pages 1 ar Department of Hea Important: If item eny injury or othe once.		21. Signature of Funeral Service License	2 26 2	22. Nai	me and Addres	ss Facility Lineral Ho Lington St	Me, RA.		1/12
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	ne death the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de		er (specify)			Month	Day Year
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of Vi	S 50	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2 E	ER/Outpatient 3	□ DOA Oth	+C rearrang richt	e 5 🗌 Residence	6 □Other (Spec	cify)
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Di∨	after Direction by	Certification:	4 Homicide determined	building, etc. (Specify)	additing a moo		City or Town, St	ate)	
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	aic	29a. Certifier 1 Certifying Phys	ician: To the best of my know	vledge, death occ	urred at the tir	ne, date and place, a	nd due to the cause	e(s) and manner as	stated.
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			1800		22a) (Trees B.)	11063	3360	9,	115/06	>
			30. Name and address of person who co	Impleted cause of death (Item	COLPANIO	- Go	neral Ho	reital	Conhic	lee mi
	St	ate	31. Date filed (Month, Day Year)	32. Registrar's Signat	ure	المال المال	W	7		0
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State of Maryland / Department of Health and Mental Hygiena 31523 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 200්දී Mary Jean Schuler Aug. 24, 5:10p /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 429 Standfort Court Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Funeral Days 1 □ M 2 X □ F Yrs Director 217-16-5131 84 Nov. 13, 1921 MD Usual Residence of Decedent the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or Iteme 23s or 28s-f show the Muzical Examiner must be notified at MD Anne Arundel Arnold Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 429 Standfort Court 21012 USA death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Maritat Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 22 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Daparment of Health and Mental Hygian Importent: If Item 27 is marked other the eny injury or other traumatic avent Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Manlove Ruth Alderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor F. Schuler/Husband 429 Standfort Court, Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Aug. 29, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 2006 Baltimore, MD 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Ho
495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funerat Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SUADDER CANSER Physician METHOTAD (/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 in the past 12 months?
1 ☐ Yes 2 ☐ No. Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknow á signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 1 No 24a Was an autopsy rmed? 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Naturat death. 2 □ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funerel Direct 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check one) and manner stated. 29b. Signature and title of co 29d. Date signed (Month, Day, Year, death (Item 23a) (Type, Print) OUR SUCH KUM SES 6-97 31. Date filed (Month, Day, Year) State AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes of A

			1 - For State Registrar	ate of Marylar		rtificate of			g. No. 2008	31524
	Physic	ian	Decedent's Name (First, Middle, Last) T. O. D. T.	M EDAVIO	D.			2. Date of Death Month	Day Yea	
	/Medi	cal	LORETTA 4a. Facility Name (If not institution, give stree	M. TAYLO)R	4b. City. Town, o	or Location of Death	SEPT.14	4c. County of De	1042
	Examir	ner	Suburban Hosp			Beth				GOMERY
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Jan. 11		Sirthplace (State or Foreign
	Director		243-58-4913 1 ¹	^{2LXF} 68	Yrs.	World Days	(10013 tviii).	Jan. II	,1938 N	New York
-	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	ecation				10d. Inside City Limits
	Maryli f sho	ō	MD Montgome		•	evy Cha	se			1√2Yes 2□No
	288	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	h with	a D	2629 Colston D	rive		2	0815		U.S.A	<i>A</i> •
	deat ms	Funeral	11. Marital Status 12. V	Vas Decedent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	merican Indian,
126	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show important: in Injury or other traumatic event, the Medical Examinar must be nutified at once.	by Fu	1 Never Married 2 Married	Yes 2X No f Yes, Give fear or Dates:	i	1 □ Yes 2 ⊡ x No		, ,	Specify:	Black
1 12	72 ho	Completed	15. Decedent's Education (Specify only highest grade con	n noleted)	16a. Dece	dent's Usual Occup	pation during most of works d)	ing 1	6b. Kind of Busines	ss/Industry
5 5	ithin Mag	ig.		College (1-4or 5+)		DO NOT use retire usewife	d)		Home	
Location	be filed w stal Hygier of other th	S	17. Father's Name (First, Middle, Last)	l yr	по	usewile	18. Mother's Name	/First Middle M		
26	d be f antal h	o Be	Wilvert Clement	a				nown	and ar Camamo,	
7	should Ind Men	ို	19a. Informant's Name/Relationship (Type, I		19b. Mailir	ng Address (Street	and Number or Rura		City or Town, State	, Zip Code)
ع تي	and 2: salth ai n 27 is		Orlando L. Taylo	r (Husban	.d) 2	629 Col	ston Dr.	, Chevy	Chase	MD 20815
aylok,	of Hei		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other pla	ce)	Date 2	0c. Location - City	or Town, State
, o E	Pages ment of ant: if It		4 Donation 5 Other (Specify)	/ Ga						Spring, MD
Taylor, Loratto	permit. Departi Import any inj		21. Signatur — Funeral Service Ucerlsee	mental						HOME, P.A. e,MD 20850
ī	40260		23a. Part1. Enter the disease, or complication	one that caused the dea	VI SUL					Approximate
			shock, or heart failure. List only one ca	use on each line.	th. Do not sin	el tile mode of dya	ig, such as cardiac t	or respiratory arres	st,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Sepsis Due to (or as a consec	nuence of):					24 Hrs
	Examiner			Non Sma		11 Lung	Cancer			9 weeks
	D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consec	quence of).	TT Hung	Carroca			J WC-0315
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events c c	Due to (or as a consec	ruence of):					
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184 Box	ie death	by Physician/M	in the past 12 months? 1 □ Yes 2 🛣 No	I□Live birth 2□Feta I□Pregnant at time of o I□Unknown		Ectopic pregnanc Other (specify)	у		Month	Day Year
60	that the de ed by the deteched	Phy	9 ☐ Unknown Part II. Other significant conditions contributions		evikina in the co		an in One I	22a Did taba	anna una nantributa	to the cause of death?
© 0/0-14-0	Attending Physician: The law requires that the redath. •ctor: After this certificate has been signed by the tyne funeral director, page 2 should be detected.	d by	Partil. Other Significant conditions continue	ning to death but not res	sulling in the u	ndenying cause giv	en in rait i.			Probably 4 Unknown
14	law requir as been si 2 should	Siete						24a. Was an		autopsy findings available
- 2	The lav	Completed						autopsy perform 1 ☐ Yes 2s	ed? death	o completion of cause of ? es 2□ No
7 =	ysician: The lis certificate hadirector, page	Be C	25. Was case referred to medical examiner?				26. Place of Death	Check only one		
>	Physic this ce al dire	2	1 ☐ Yes 2 ☐ No Hosp	1 Inpatient 2	ER/Outpatier	nt 3□ DOA Ott	ner: 4 Nursing Ho	me 5 🗆 Resider	nce 6 Other (S	pecify)
۶	ding P		t Natural 5 ☐ Pending	8a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	rk?	28d. Describe hov	w injury occurred	
. <u>.</u>	death death the 1	cat	2 Accident investigation 3 Suicide 6 Could not be	Se. Place of Injury - At h	ome farm str		Yes 2 □ No	28f Location (Stre	aet and Number or	Rural Route Number.
<u>;</u>	after Direct	Certification;	4 Homicide determined	building, etc. (Speci		est, ractory, office		City or Town,		riarai riosto resmosi,
	To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral		29a. Certifier (Check only 2 Medical Examiner:	n: To the best of my kn On the basis of examina	owledge, deat	h occurred at the til	me, date and place,	and due to the car	use(s) and manner	as stated.
	To the within 24	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens			d. Date signed (Mo	
	-		17/15	18	Main	D22			Sept. 15	
	15		30. Name and address of person who complete	eted cause of death (Ite	m 23a) (Type.					
			5454 Wisconsin A	ve., Chev	y Cha	se, MD				
10	St Regist	ate	31. Date filed (Month, Day, Year) SEP 2 0 200	32. Angistrar's Sign	ature	carle				

State of Maryland / Department of Health and Mental Hygiens 0 0 6 31525 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death ^{Day} 2006 Year **Physician** Month 16, Sept. 12:30 pM Nicholas Lewis Talbot /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chesapeake Woods Center Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 27, 1937 9. Birthplace (State or Foreign Country) England Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10M 2 F 69 Yrs. 564-40-7131 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Mudical Examiner must be outified at 1 Yes 2 No Directo Vienna Maryland Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with items 23a or 21869 **USA** 122 Market St. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 Yes 2 No Specify ģ White 3 Widowed 4 Divorced 'naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Fire Protection Engineer Insurance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill timent of Health and Mental Hitem 27 is marked oit Clara Smith Percival Talbot 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 234, Vienna, MD 21869 Judith A. Talbot/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. MidShoreCremationCenter 9/18/2006 Cambridge, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Algnature of Funeral Service Licensee thread 23a Fart1. Enter the fisea or complications that caused the death. Do not shock, or heart 15 are. List only one caus ion each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CORONARY artery 40005 /Medical Due to (or as a consequence of): Examiner Cardiomyo path Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Vascular cerebral Due to (or as a consequence of) attending physicien for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □Unknown been 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? certificete 1 Yes 2 N6 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Mursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the f within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō Medical 29a. Certifier t 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 40059973 husan 30. Name an dress of person who completed cause of death (Item 23a) (Type, Print) 100 Bramble Street, Cambridge 31. Date filed (Month, Day, Year 32. Pagistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 0 0 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sept. 07, 2006 6:50 PM Suzanna Urspruch Linda /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Michaels 108 Grace Street Talbot If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Jan. 28, 1 7 Age (In vrs last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2**K**) F 217-52-4300 57 Director 1940 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. nnt: if Item 27 is marked other then "netural", or iteme 23e or 28a-f ehow 10a State 10c. City. Town or Location 10d. Inside City Limits 10b County r 28a-f ehow MD Talbot 1 ☑ Yes 2 No Director St. Michaels 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a or 2 108 Grace Street United States 21663 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 5 Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 → Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White r then "netural", o 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Personal Assistant Estate Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Gordon Urspruch Charlotte Albert ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Urspruch/Brother P.O. Box 772, St. Michaels, MD 21663 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition important: If it eny injury or o gage. 1 Burial 2 Cremation 3 Removal from State Anatomy Gift Registry 9/08/06 4x Donation 5 ☐ Other (Specify) Hanover, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mes disease or condition resulting in death) allenona /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No certificete has been si rector, page 2 should b Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physicien: ; After this certifical funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 28c. Injury at Work? Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending death. Director; / 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. To the I 29b. Signature and title of certifier 2 $\Lambda \Lambda$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DeShields MD 401 32. Registrar's Signature State Registrar

	1	For State Registrar	State of M	1aryland		artment rtificate			Mental Hy	giene Reg. No.2	006	31527	1
Physicia		1. Decedent's Name (First, Middle,	Last)	0	1/21	lest	1.0.4		2. Date of De	Day) Year	3. Time of Death	
/Medic Examin	_	4a. Facility Name (If not institution,				4b. City, 1	Town, or	Location of Dea		4c. Cc	unty of Death		_
		Howard County 5. Social Security Number	6-ene/A1 5. Sex 7. A	Hosp age (In yrs. Ia		If Under	1 Year	1614 If Under 24 Hrs	8. Date of Bi		HO WA	place (State or Foreign	
Funeral Director		243-66 - 2214	1□M 2ਊF	62	Yrs.	Months	Days	Hours Min		1943	Cou	h Carolina	
and *		Usual Residence of Decedent 10a, State 10b, County		10c. City	, Town or Lo	cation						10d. Inside City Limits	_
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9 W ==	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat	tient 2 🗆 E	ER/Outpatien	nt 3 DO	A Othe	05	Home 5□Res		Other (Special	fy)	
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		30. Name and address of person w	ho completed cause of	death (Item	23a) (Type,	Prifit)	アブコ	- Cod	V4	Coli	16 =	2006	
Sta		31. Date filed (Month, Day, Year)	A. C.	strar's Signat	ture	40 7	,		•	00,00	· · · · · · · · · · · · · · · · · · ·	21-49.	1
Registr	ar	SEP 20	2006	10 M	Sign Sign	94.53)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 200 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Sept. Пау **Physician** 1820 P.M VALENZUELA MARTHA 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITAL HOWARD COLUMBIA 5. Social Security Number It Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Director 86 APR 26, MARYLAND 213-34-2540 1920 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hygiene. Important: If itsm 27 is marked other than "natural", or items 23a or 28e-4 e.h.... any injury or other traumatic event, the Medical France Process. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Be Completed by Funeral Director MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10132 SPRING POOLS LANE 21044 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN W. PAYNE CLAIRE NOBLE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREG VALENZUELA/SON 23 JOHN COURT, RANDOLPH NJ 07869 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, crematory or other place) CHESAPEAKE CREMATION CTR 9/11/2006 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** colon disease or condition resulting in death) Metastaha Cancer week /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time ot death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown 24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient X ER/Outpatient 3 DOA 1 ☐ Yes & No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death.
i Director: Aft investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

Box 68760,

Division of Vital Records, P.O.

anze 31. Date filed (Month By State Registrar

29b. Signature and title of certifier

MD, FCCP

30. Name and address of person who completed cause of death (II m 23a) (Type, Print) Man-Clin hay uyen, MD,

29c. License number

D 36845

29d. Date signed (Month, Day, Year)

Sept. 09, 2006

	-	For State Registrar		State of Mar		partment of F prtificate of			jiene [106	31529
Physicia	n	Decedent's Name (First, ALBERT VYT)						2. Date of Dea Month SEPTEME	Day	Year 2006	3. Time of Death 0318AM M
/Medic Examin		4a. Facility Name (If not ins		reet and number)		4b. City, Town, o	r Location of Death	1		inty of Death	OJIOMI
ZXX		TALBOT HOS					ASTON			TALBOT	
Funeral Director		5. Social Security Number 048-09-0525			(In yrs. last birthda 36 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV 29	1919	9. Birthpl Count PA	ace (State or Foreign try)
land ow	}	Usual Residence of Deceder 10a. State 10b. C			10c. City, Town or	Location				10	Od. Inside City Limits
Mary 1-f sh	tor	MD	TALBOT		EASTO	N					1 ☐ Yes 2 🛣 No
ith the Marylan or 28a-f show te rivillise at	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Count	try?
s 23e	rai	26480 ARCA		ORES CIRCI 2. Was Decedent Ev			1601	necify Yes or No-	14 5	US/ Race - America	
ie, iwal yiatid Zizioooo	by Funeral	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ Div	Married	Armed Forces? 1▼ Yes 2 □ No If Yes, Give Year or Dates:)	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Puert	Rican, etc.)	1	Black, White, e	etc.
72 hou	eted		cedent's Educ highest grade		16a. Dec	cedent's Usual Occup ve kind of work done	pation during most of wor	king	16b. Kind o	of Business/Ind	lustry
vithin ne.	Completed	Elementary/Secondary (College (1-4or 5+)	ve kind of work done . DO NOT use retire	d)		TOT	DEADMC	
Hygie ther t		12 17. Father's Name (First, M	liddle, Last)	0	GU	NSMITH	18. Mother's Nan	ne (First, Middle,		REARMS	
should be filed within to Mental Hygiene. marked other than matic event, it a Mental Hygiene.	To Be		NOWN				URSUI	A UNK	NOWN		
i, IVICITYICA and 2 should i saith and Meni n 27 is marke ier traumatic		19a. Informant's Name/Re ANN MARIE DO				iling Address (Street					Code)
		20a. Method of Disposition 1 Burial 2 Crem 4 Donation 5 0		emoval from State	cemetery, c	position (Name of rematory or other pla	1	Date 9/15/200		on - City or To	wn, State
permit. Page Department of Important: If any Injury or		21. Signature of Funeral S	1	owsk. Cf.	E F	22. Name and Addre ELLOWS, H 200 S. HAR	ess of Facility ELFENBEIN	N & NEWN	AM FUN	IERAL H	OME PA
		23a. Part1. Enter the dises shock, or heart failure	ase, or complice. List only one	e cause on each line	he death. Do not e	enter the mode of dyi	ng, such as cardiac				Approximate Interval Between Onset and Death
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.		consequence of):	CANCER	7				
Examiner		Sequentially list conditions	,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
pe is	iner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury)	• 1	Due to (or as a	consequence of):						
executed executed in and rial-transit	Examin	that initiated events c									
certificate be executed certificate be executed and ording physician and use as the burial-transit	ca		d.								
A OC Sertifica ding pl	/Medi	IF FEMALE:	23	3c. If yes, outcome o	f pregnancy				234	Date of delive	nov.
death death e atter	Physician/M	in the past 12 months 1 Yes 2 No 9 Unknown	ant	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other <i>(specify)</i> _	у		250.	23d. Date of delivery Month Day Year	
ecords, F.O law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant c	onditions con	tributing to death but	t not resulting in the	e underlying cause gr	ven in Part I.	23e. Did to	bacco use	contribute to th	e cause of death?
law requires as been sign								101	′es 2□N	o 3 ☐ Prob	ably 4 Nonknown
e la has	Completed									4b. Were autop prior to con death? 1 ☐ Yes	psy findings available inpletion of cause of 2 No
vicai n sician: The certificate h rector, page	BeC	25. Was case referred to rexaminer?						ath (Check only o	#		
Physic Physic rthis ca	မှ	1 ☐ Yes 2 No	H	ospital: 1 lnpatien 28a. Date of Injury	t 2 ER/Outpat	ient 3L DOA		lome 5 Resid			HOSPICE
ding P. After funer	tlon		Pending investigation	(Month, Day	Year) Injur	y Wo	rk?]Yes 2 □No	28G. Describe 1	iow injury oc	,001100	
LIVISION f or Attending after death. Director: After	Certification:	Z [] Accident	Could not be determined	28e. Place of Injur- building, etc.	ry - At home, farm, (Specify)	street, factory, office	4 11	28f. Location (S City or Tox		umber or Rura	l Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical C	29a. Certifier 1 C (Check only 2 M	ertifying Phys edical Examir	sician: To the best of ner: On the basis of and manner stat	examination and/or	eath occurred at the trinvestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and date and pla	d manner as stace, and due to	ated. o the cause(s)
To th within To th comp	Me	29b. Signature and title of	certifier	L.			se number			gned (Month,	
		· K	mes V	(Allinson)	in	120	005190	8'	9	15/0	6
(1/x/1/k)		30. Name and address of	rJ.	PATIENG	eath (Item 23a) (Type SDD)	se, Print) S. EM/Sof	85 95	. MICH	1245	MAD	
Sta Regist		31. Date filed (Month, Day		32. Registra	Signature	the Stand	9				

		•	For State Registrar		State of	Maryland		artment of tificate of				giene Reg. No.2	006	31530
	Physici		1. Decedent's Name (First								2. Date of Dea	Day	Year 2006	3. Time of Death 1
	/Medio Examin		Fong Lee 4a. Facility Name (If not i		reet and num			4b. City, Town,	or Location	n of Death	ungus		nty of Death	
			Baltimore 5. Social Security Number		gton	Medical		Glen If Under 1 Year	Bur 20	IC Br 24 Hrs.	8. Date of Birt	h	E ARU	ADEL lace (State or Foreign try)
- 1	Funeral Director		214-21-4184	1 10	M 2∑1F	63	Yrs.	Months Day	s Hours		Nov. 6	y, Year)	Count	Vietnam
	land ow			. County		10c. City	, Town or Lo						10	0d. Inside City Limits
	e Maryland 3a-f ehow	ctor	MD	Anne Aru	ndel 			Seve	rna P	ark				1 ☐ Yes 2X No
	death with the	Dire	10e. Street and Number					10f. Zip Code				10g. Citizen	of What Count	try?
9800	72 hours after "natural", or ite ofcel Exemire	d by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 U	2(X) Married Divorced	Armed Ford 1 _Yes 2 If Yes, Give Year or Da	2 ⊠ No		Was Decedent of f Yes, specify Cu I ☐ Yes 2XN	o Specif		ecify Yes or No Rican, etc.)	ify Yes or No- lican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Vietnamese		
∩ G 1215-0		Completed		Decedent's Educ thy highest grade (0-12)		4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)						Business/Ind	
+ COG land 21215-0036	be filed stal Hygind other	To Be Co	17. Father's Name (First, Chapphu Vuo							ther's Name	e (First, Middle,			
lary	2 should and Mer is marks sumatic	1	19a. Informant's Name/F		e, Print)			ng Address (Stre						Code)
e, ∠	1 and Health em 27 other tr		Quyen Luono	-		20b. P	lace of Dispo	McKin W sition (Name of			a Park,		11146 on - City or Tox	wn, State
	Pages nent of int: If It		1 ☑ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐	emation 3 Re	moval from S	iaie I	-	natory or other p en Cemet			. 30, 2006	Glen	Burnie	, MD
VU ON Baltimore,	permit. Pages 1 an Depertment of Heat Important: If Item 2 any Injury or other anea.		21. Signature of Purphal	Service licens	an	<u> </u>	Ba	Name and Add arranco 5 Gov.	& Son Ritch	is, P.	A. Seve	rna Pa rna Pa	rk Fun	eral Home 21146
8760,	Physician /Medical Examiner The burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition and the cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	ſª	Dua to (a	or as a consequence as a consequence or a consequence	uanga of).	- 7	To	id	Com	CAY		Onset and Death
P.O. Box 68	Attending Physician: The law requires that the death certificate be executed rideath. cleath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Med	IF FEMALE: 23b. Was decedent precint the past 12 mont 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	gnant	1 Live bit	ome of pregna th 2 □ Fetel int at time of de wn	Ideath 3	Ectopic pregnar Other (specify)	осу				Date of delive Month	ory Day Year
S, P	es that igned b be deta	5	Part II. Other significent			ath but not resu	ulting in the u	nderlying cause	given in Pai	rt I.				e cause of death?
Sord	w requir been s should	Completed		LNEM	100						1 []`			ably 4 □Unknown psy findings available
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Vital	sician; The la certificate has irector, page 2	Be	25. Was case referred to examiner?		ospital:				thon		h (Check only o	one)		
o	g Phys er this eral dir	n: To	1 ☐ Yes 2 🙀 No 27. Manner of Death		i ligin	patient 2 f Injury n, Day Year)	28b. Time o	IL SU DOA			me 5 Resident)
Division of Vital Records,	ttending death. ctor: After y the funer	Certification:	2 Accident	Pending investigation Could not be			Injury		□Yes 2		28f Location /	Street and No	imber or Rumi	I Route Number,
Divi	tal or Al	Certif	4 Homicide	determined	buildin	g, etc. (Specif)	y)	еет, гастогу, отно	e 		City or To	wn, State)	inder or notal	noute Number,
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi	edicai	(Check only 2)	Certifying Phys Medical Examin	ician: To the er: On the ba and mann	sis of examina	wledge, deat tion and/or in	vestigation, in m	y opinion, d	leath occur	and due to the red at the time,	date and place	e, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title	of certifier	1,0	, the	mD	29c. Lice	nse numbe	er - 8	-	29d. Date sig	ned (Month, I	Day, Year)
			30. Name and address of	of person who co	mpleted cause	of death (Item	n 23a) (Type,	Print)	harl	æ\$	E (0)	Les I	I MID	en Barnie Mi
	3		Balt wer		5 hine	gistrar's Signa	eclica	1 Cent	ar	301	Hospi	tal Dr	: Gl	EN BLYNIE MI
	Sta Regist	ate rar	AU			bear !	B /4	me						

State of Maryland / Department of Health and Mental Hygiene 006 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle Last) Ep Comber Dav **Physician** 06:00 AM 2006 Benjamin Ross Wallace /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Since Hospital of C14 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 22, 1 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Days Hours 1**⊠**M 2□ F Months 85 214-12-4152 Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene.

ant: if item 27 is marked other then "natural; or items 23a or 28a-f show ury or other traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 XYes 2 ☐ No Directo Baltimore Gwynn Oak 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 USA 1912 Englewood Avenue by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Year or Dates: WWII 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) engineer aviation 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony Ross Wallace Barbara Casten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Heelth a Important: if Item 27 is any injury or other training once. Charlene Wallace wife 1912 Englewood Ave., Gwynn Oak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 9/12/06 Church Creek, MD 4 ☐ Donation 5 ☐ Other (Specify) Old Trinity Churchyard 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 Approximate Interval Between Onset and Death 23a. PartiVEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tallive Immediate Cause (Final Respira Forg Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neu monce f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Le wis The law requires that the death certificate be executed attending physicien end for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1) ementice 1 Yes 2 2 No 3 Probably 4 Unknown Congestive Hear failure 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Wasan autopsy performed? chiseose Conney 2 No 1 Yes Hospital or Attending Physician: After this certification, funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerei Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Scor Borton, MD September 9, 2006 12ES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSCAR V. BAICON, MD Sinux (IDSp/Tal) 2401 West Belvedere Avenue Baltimore, MD 21215 Sinui Hospital of Galtimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

, BENJAMIN

WALLACE

ORIGINAL

State of Maryland / Department of Health and Mental Hygien) 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** \mathbf{P}^{M} SEPTEMBER 23 2006 12:50 ADAM JOHN WATKOWSKI, JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner OUEEN ANNE'S** 1404 QUEEN ANNE'S DRIVE CHESTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 12MM 2□ F 12/17/1929 MD 218-26-4902 **Director** 76 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County rthan "natural", or Itams 23a or 28a-1 show the Medical Examinar must be notified at 1 ☐ Yes 2X No Director QUEEN ANNE'S CHESTER MD 10n, Citizen of What Country? 10f. Zip Code 10e. Street and Number 1404 QUEEN ANNE'S DRIVE 21619 USA death v Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status a filed within 72 hours after all Hygiene.

Hygiene.

other than "natural", or Ita 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: <u>۾</u> WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR MANUFACTURING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any july or other traumatic event 2008. Be ADAM ANTHONY WATKOWSKI FRANCES ANNA WITKOWSKI ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 1404 QUEEN ANNE'S DRIVE, CHESTER, MD 21619 MARGARET ROSE WATKOWSKI / WIFE Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 09/28/2006 BALTIMORE, MD ¹ 4 □ Donation 5 □ Other (Specify) HOLY CROSS CEMETERY 21. Signature A Funeral Sarvice FFILOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death out cell Immediate Cause (Final MO5 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? ō 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the al ☐Yes 2☐No Records, P.O. 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tes 2□ No 1 ☐ Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 2) No ctor: After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. investigation or Attendation of Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide To the Hospital o within 24 hours aft To the Funeral Di 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date, signed (Month, Day, Year) 9 24 2006 29b. Signature and title of certifier Bestgate Rd. Annapolis, and. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Strart E. Seloui G., W.D. 900 5 dw 31. Date filed (Month, Day, Year) SEP 2 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryland		artment of He tificate of D		Mental Hy	giene 0 (36 3	1533
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of D Month	eath Day	Year 3.	Time of Death
	/Medic	cal	Eleanor B. Wainwri	0		4b. City, Town, or L	ocation of Death	9	14 20 4c. County	006 of Death	1210 ™
	Examir	ier	8657 Nine Pin Bra			Berlin				cester	
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	irth		(State or Foreign
	Director		218-24-3812 Usuat Residence of Decedent	300	Yrs.			4 1	2 1926	Worce	ster
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation					Inside City Limits
	Ba-fel	Director	MD Worceste	er Ber	lin						1 ☐ Yes 2√☐ No
	with th		10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?	
	Jeath ne 23	Funerai	8657 Nine Pin Bra	12. Was Decedent Ever in U.S	S. 13. V	21811 Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (S	pecify Yes or N	USA o- 14 Race	e - American Ir	ndian,
920	is 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. Item 27 is marked other than "naturel," or Itame 28 or 28s-f show other traumatic avent, the Medical Examination must be notified at	by Fun	1 Never Married 2 Married 3 Widowed 42 Divorced	Armed Forces? 1 ☐ Yes 2 A No If Yes, Give Year or Dates:	i		Mexican, Puert Specify:	o Rican, etc.)		k, White, etc. White	
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121	within	mpf	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired)	·		O II.		
0	Hygie Hygie other		17. Father's Name (First, Middle, Last)		nou		8. Mother's Nan	ne (First, Middle	Own Ho		
Baltimore, Maryland 21215-0036	Jental Jental Jental Jic av	To Be	Robins Bowen				Pauline	Quille	en		
lary	2 shol		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	ig Address (Street an	d Number or Ru	ral Route Numi	ber, City or Town,	State, Zip Coo	ie)
e,	1 and 4ealth am 27 ther tr		Robin Littleton 20a. Method of Disposition	20b Pt		Bethel Restrict Name of		ards, 1	MD 21874 20c. Location -	City or Town	State
nor	Pages nent of P int; if its		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	ieniovan nom State		sition (Name of natory or other place) open Crem	1				Otato
ati.	permit. Pages Department of Importent; if it any injury or o		21. Signature of Funeral Service License			. Name and Address		3/2006 Burbas	Frankfor	1 Home	
ñ	Deg imb		Yazzuelia	1 Robbette	1	08 Willian	n St., H	Berlin,	MD 21811	. Home	
	Physician		23a. Part1. Enter the disease, or compt shock, or heart failure. List control tmmediate Cause (Final disease or condition	cations that cauted the death ne cause on each line. Atheroscler					arrest,	Inte	proximate erval Between set and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ							
	4	e.	Sequentially list conditions, if any, leading to immediate	Hypertensio							
	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Hyperlipide	mia						
Ŏ,	icate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):						
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D. Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached tor use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown		23d. Date of delivery Month Day Year					
, P.O.	thet the		Part II. Other significant conditions con	ntributing to death but not resu	Iting in the ur	nderlying cause given	in Part I.	23e. Did	tobacco use conti	ribute to the ca	ause of death?
rds	w requires been sign should be	ed by						1 🗆	Yes 2 2No	3 Probably	4 □Unknown
Division of Vital Records,	nysicien: The law re nis certiticete has ber I director, page 2 sho	Completed							opsy formed?	Were autopsy forior to completeath?	findings available tion of cause of
/ita	cien: ertitica ector,	Be	25. Was case referred to medical examiner?	1			26. Place of Dea	th (Check only	one)		
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	9 4 F 9	Medical (29a. Certifier 1 Certifying Phy: (Check order 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	vledge, death ion and/or inv	n occurred at the time vestigation, in my opin	, date and place nion, death occu	, and due to the rred at the time	e cause(s) and ma , date and place, a	nner as stated and due to the	I. cause(s)
	To the within 2 To the complet	Ψ	29b Signature and title of certifier	Xa	W	29c. License	number		29d. Date signed	(Month, Day,	Year)
)			Of week		/	D46257	7		Sept. 18	, 2006	
8	T 6		30. Name and address of person who co Edwin Castaneda,	M.D. 10324 0	ld Oce	an City Bl	vd., Be	rlin, M	ld. 21811		
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 0 20	32. egistrar's Signat	# A	medi					

06-07074 Please Type or Print in Black Indelible Ink Linda Wallace State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year September 19, 2006 Medical Examine 0404 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dorchester General Hospital Cmbridge Dorchester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth/MM/DD/YYYY 9 Birthplace (State or **Funeral** Foreign New Months Days Hours Director Country) JERSEY Usual Residence of Decedent 10b. County Oc. City, Town or Location 10d. Inside City Limits √Yes 2 'natural", or items 23a or 28a-f show Examiner must be notified at once. No Director 10e. Street and Number 10g. Citizen of What Country Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14 Race - American Indian. Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married 2 Yes 2 No If Yes, Give Year 1 Yes 2 No specify Widowed 4 Divorced ģ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done Completed - 1 215-0036
- 1 and 2 should be filed within 72 hou trument of Health and Mental Hygiene stant: If item 27 is mark. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) Be ٩ 19a Inform 19b. Mailing Address Ve. NIJ. Place of Disposition (Nar crematory or other place Burial 2 Cremation 3 Removal from State Important: Donation 5 Other Specify rematory 22. Name and Address of Facility
I TENRY FUNCISAL ture of Funeral Service License ambri 10 Washington MD. 2/613 Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** feilure. List only one cause on each line /Medical Death a. Hypertensive Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? death? After this certificate ✓ Yes 2 1 🗸 Yes 25 Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital. 1 Inpatient 2 🗸 ER/Outpatient 3 Other₄ DOA Nursing Home 5 Residence 6 2 1 Yes 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending 1 Yes 2 No hours after death To the Funeral Director: the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ure and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. September 20, 2006 Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month.

State

Registrar

2006

			1 - For State Registrar	State of Marylan		artment of H rtificate of		ental Hygien	Z U U b	31535
	Physici	an	Decedent's Name (First, Middle, Last	t)				2. Date of Death Month D	ay Year	3. Time of Death
	/Medic		411 111	0009				Sept 1	7 2001	
7	Examin	er	4a. Facility Name (If not institution, give		040		or Location of Death	4	ic. County of Deati	h
			University of Mars 5. Social Security Number 6. S	•		Baltin If Under 1 Year	T 11 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	8. Date of Birth		nplace (State or Foreign
	Funeral Director			□M 201 4 8	Yrs.	Months Days	Hours Min.	(Month, Day, Yea	500 180	untry)
			Usual Residence of Decedent	70				may 3, 19	20 1110	aryland
7	how		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
7	B Ma	cto	MD. Caro	line F	res	ston				1 ∰Yes 2 No
\$	or 28	Oire	10e. Street and Number		1	10f. Zip Code	, , , , , , , , , , , , , , , , , , , ,	10g. 0	Citizen of What Co	untry?
7	death with the Maryland me 23a or 28a-f ehow rouat be notified at	ra		Pine Roa	0	21	655		USA	
	er de	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spec ean, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs aft	byF	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 12 No	Specify:		Specify: A 1	ack
ခို	be ilied within 72 hours after death with the Marylan stal Hygiene. ed other then "naturel", or iteme 23a or 28a-f ehow event, the Madical Exameler must be notified at	ed	15. Decedent's Ec	ucation		dent's Usual Occup		16b.	Kind of Business/	
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p	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)	,			18. Mother's Name	(First, Middle, Maide	en Sumame)	
<u>ya</u>	hould be id Menta marked matic ev	၉	Walter		een		Glad		aikes	
Maryland 21215-0036	2 9 5 3		19a. Informant's Name/Relationship (19b. Maili	A / .	and Number or Rural	1- 1	or Town, State, 2	
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Baltimore	Pages ent of I int: if its		1 🖫 Burial 2 □ Cremation 3 □	Removal from State	emetery, cre	matory or other pla	(ce)	,	,	
듈	artmen ordent: injury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer	" Gui			letery 9/2		iston, M	aryland
Ba	permit. Pag Department Importent: i any injury o		Day ollo	2/0421	2 /	IENRY F	uneral H	Lome, P. A.	1 1 11	07/613
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ŀ	Physician	2 7	shock, or heart failure. List only Immediate Cause (Final		~		h!	c !		Interval Between Onset and Death
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687	licate phys s the	dicai		. d						
Box (the death certific y the ettending p iched for use as	M/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of deli	iverv
	death e ette d for	Ca	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnanc Other (specify)	y		Month	Day Year
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မင	e law r hes be je 2 sh	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
<u>=</u>	The cete h	ပ္ပ						performed? 1 ☐ Yes 2 Ø N	death?	2 No
Vita	Physicien: r this certific ral director,	Be	25. Was case referred to medicat examiner?	Hospital:		104	26. Place of Death	(Check only one)		
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á	ai or i Dire	Certification:	4 Homicide	building, etc. (Specif	y)			City or Town, Sta	ite)	
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funerel Director: Attenthis certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifyin 1 Ph (Check only 2 Medical Exam	ysician: To the best of my kno	wledge deal	h accurred at the ti	ma, data and place, a	nd dualty the cruse	(s) and manner as	stated
	the H in 24 the Fi	edical	one)	niner: On the basis of examina and manner stated.	uon and/or in			a at the time, date a	nd place, and due	to the cause(s)
	To To To To	Σ	29b. Signature and title of certifier	W M O		29c. Licens		I .	Date signed (Month	
,			Delina Naya	K M.D		111	144	Set	ot 17 2	2006
			30. Name and address of person who				Baltimor	m Mn 2.	201	
	Sta	10	31. Date filed (Month, Day, Year)	32. Registrar's Signa		IL STIELL	1011111101	01110 21	201	
	310	rte.		2006	20	Acres 16 1				

State of Maryland / Department of Health and Mental Hygien 006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 12_P ^M В. ZUKOWSKI SEPT 16, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILLENNIUM HEALTH & REHABILITATION EDGEWATER
If Under 1 Year | If Under 24 Hrs. ANNE ARUNDEL Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Yrs. 96 **Director** 213 42 6367 MARCH 30,1910 IDAHO Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar must be exitting at 1 ☐ Yes 2 🙀 No Director MARYLAND ANNE ARUNDEL EDGEWATER 10e, Street and Number 10f. Zio Code 10g, Citizen of What Country? 3408 GLEBE DRIVE death v 21037 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status withIn 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ 3 ₩ Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER YEARS HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked tany injury or other traumatic events. BROSSARD LOUIS STELLA FISHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ZUKOWSKI JAN B. (SON) 3408 GLEBE DRIVE _ EDGEWATER, MD. 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9-28-06 '4 Donation 5 Dother (Specify) ARLINGTON NATIONAL ARLINGTON. VA. 21. Signatur of Funeral Septice Lensee 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDCEWATER, MP. 21037

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) diac Physician /Medical Due to (or as a consequence of): Examiner une Sequentially list conditions sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital hospitel or Attending Physician: 24 hours after death. I Funeral Director: After this certificately filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4V Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funeral Completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature d title of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State SEP 1 9 2006 Registrar

		-	For For Registrar	State of Maryla	nd / Depa		lealth a		ntal Hygie	ene No.20	06	31537
H	Physicia	an	1. Decedent's Name (First, Middle, Last)						Date of Death Month	Day 3	Year 2006	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	LER		4b. City, Town,	or Location of		OCTOBER	4c. Count	-	1,5(2,
	Examin	er	WORTHWEST		AL		SALLS		N		BALTIM	IORE
	Funeral Director		5. Social Security Number 6. Security 111-12-5933	7. Age (In yr	s. last birthday) 39 Yrs.	If Under 1 Year Months Days		Min. 8	Date of Birth (Month, Day) 08/16/19	917	9. Birthpl Coun	ace (State or Foreign frx) GERMANY
1	and	}	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation					10	Od. Inside City Limits
	Maryi f ehc	ξ	MD N/A		BAL	TIMORE						1 X Yes 2 □ No
:	or 288	Director	10e. Street and Number			10f. Zip Code	0101	-	10g	. Citizen of	What Coun	
	ath wi	rai	2603 WHITNEY AVE			W- 5 1 (2121		Y. Van as Na	14 Pa	ce - Americ	USA
ر م	within 72 hours after death with the Maryland iene. Then "naturel", or Items 23e or 28e-f ehow The Medical Exam or must be molified at	by Funerai	11, Marital Status 1 Never Married 2 Married 3 Nidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 💢 No		Puerto Ri	can, etc.)		ack, White,		
9500-G	nature	ted	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during most	of working	16	b. Kind of E	Business/Inc	dustry
N	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		DO NOT use retire AL EDUCA				F	EDUCAT	TON
N	filed w Hygier other ti		17. Father's Name (First, Middle, Last)	JT.	SELCIA	AL LUUCA			First, Middle, Ma			1011
Van	d Mental I	To Be	BERNARD 19a. Informant's Name/Relationship (7)		TECKELM	ACHER		RIETT		City or Town	VANGE	
Zaz	id 2 st lth and 27 is r traur			GHTER		3 WHITNE						
ē,	s 1 an f Heal item 2 other	li	20a. Method of Disposition	206	p. Place of Disper- cemetery, cre	osition (Name of matory or other pl	ace)	Dat	te 20	c. Location	- City or To	wn, State
CHEVRA AHAVAS CHESED 10/04/2006 RANDALL						_LST0W	IN, MD					
Baltimore,	permit. I Departm Importal eny inju	1	21. Signature of Funeral Service Ucen	Maer	10	2. Name and Addi	STERST	OWN R	LEVINS	I KESV		INC. MD 21208
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only g Immediate Cause (Finat disease or condition resulting in death)	lications that caused the decause on each line. a	rive (CAPD (OF	ing, such as	THY	respiratory arres	.t.		Approximate Interval Between Onset and Death
_	ate be executed thysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons d.								
Division of Vital Records, P.O. Box 68	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Completed by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ∰No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□Ectopic pregnan	су				ate of delive	ery Day Year
ds, P.	juires that the de n signed by the a ild be detached i	d by Ph	Part II. Other significant conditions of	ontributing to death but not	resulting in the (underlying cause g	iven in Part I.			ccouse co 2 □ No	ntribute to tl 3 ☐ Prob	ne cause of death? pably 4 Unknown
Reco	The law requirate has been single 2 should	omplete							24a. Was an autopsy perform		prior to co death?	psy findings available mpletion of cause of 2 Po
ita	ian: artifica ctor, p	BeC	25. Was case referred to medical examiner?					of Death	(Check only one)		
<u>}</u>	hysic this ce al dire	2	1 ☐ Yes 2 No		28b. Time	ALL DOW			e 5 Resider			(y)
uc	ding F	ion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	r) Injury	W	ork? ⊒Yes 2 🔲		od. Describe no	Tinjury occi	anou	
Divisi	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, s ecify)				8f. Location (Stre City or Town,		mber or Rura	al Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier Check only one) Certifying Ph	ysicien: To the best of my ninar: On the basis of exam and manner stated.	knowledge, dea nination and/or i	ith occurred at the nvestigation, in my	time, date an opinion, dea	d ptace, ar	nd due to the car d at the time, da	use(s) and r te and place	manner as s	stated. the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	1			nse number				ned (Month,	
	-		1	11-00		D 2	4352	-	0	C7013E	ER 3	3006
	3		30. Name and address of person who and NOTHWEST HOSE			o, Print) Mil	reza O RAN	TOSO	STOWN	MD	21133	
	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 0CT 0 5 2005											

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0 **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner NIA inda Nursing Home mare If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7. Age (In yrs. Tast birthday)
Yrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🛣 F 250 -22-5435 South (arilina Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ehow item 27 is marked other than "naturel", or itema 23a or 28a-f shov other traumatic event, the Maylical Examiner must be notified at # SYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after c Deportment of Health and Mental Hygiene Important: if from 27 is marked other than "naturel", or item any injury or other traumatic event, the Medical Executa I □ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify. 1ac 2 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coflege (1-4or 5+) eautice 12-th as year 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) osa Willie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fordleigh Balto, md. 3809 Rene -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) atorsville, netro Cremator 21. Signature of Funeral Service 22. Name and Address of Facility Fred HILTON 70 Barto, md, 21229 march Fune Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1. Immediate Cause (Final disease or condition resulting in death) Physician Imall nsis /Medical Due to (or as a consequence of): Examiner 5x rentally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 ponths? 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Hinknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has b autopsy performed 2 🗆 No 2 No Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) Time of 28d. Describe how injury occurred 1 Matural 5 Pending Injury investigation within 24 hours after death To the Funeral Diractor: / completely filled in by the f 2 Accident 6 Could not be 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person wh 3 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 0 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 8: 40 PM BAILEY, Jr. SEPT THERN 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AVENUE BALHURE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year | Min. 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 72 Yrs 4875 Director MAKY/NWO Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ent: If Item 27 ie marked other then "naturel", or Iteme 23a or 28a-f show ury or other treumatic event, the Medical Executing creates notified as 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Be Completed by Funeral Director BAIHNUR MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USB 2115 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1/53 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Tes 2 P€No Specify: Black Specify: 3. Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MARMACY IECHNICIAN 124 Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ELMER BAILEY ٩ ANGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STID TALL GASS Ranpallshur, Med 21133 DAUGHEN LUSALINO 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 10/3/06 permit. Page Depertment of Importent: If eny injury or once. Hemorial forle WOUDLAND MAN, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHATMAN - HAWLIS FUNERAL Alma 21. Signature of Funeral Service Liceny ee Keis renstown Ballwish Md 2/21 KUMO 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemic Cardionyspath Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Medical Certification: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) burial-transit The law requires thet the death certificate be executed vv Mit that initiated events resulting in death) Last Due to (or as a consequence of use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cancer 1 Yes 2 No 3 Probably 4 → Inknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 21 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Records, P.O. Box 68760, Division of Vital Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifical completely filled in by the funeral director. To the

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) OCT 0 5 2006

(Check only one)

29b. Signature and title of certifier

 \mathcal{N}



30. Name and addres of person who completed cause of death (Item 23a) (Type, Print)

Calver

5+

Bulto

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 24/06

			1 - For Amend item#10e,	State of Ma 19b, perInf,	ryland / D , G860 10/	epartment of F Sertificate of	lealth and I Death	Mental Hygie	ne . N2 0 0 6	31540
	n		1. Decedent's Name (First, Middle, Las	t)				2. Date of Death		3. Time of Death
	Physici /Medic		Kenneth Paul Burr	ns 				Septembe	r 30, 200	06 1:00 A.M
	Examin		4a. Facility Name (If not institution, give				Location of Death	n	4c. County of Dea	
			Charlestown Care 5. Social Security Number 6. Se		(In yrs. last birth	Catonsv	7ille If Under 24 Hrs.	8. Date of Birth	Balti	
	Funeral Director		708-03-9534	x 2□F 89		rs. Months Days	Hours Min.	(Month, Day, Y Oct.2, 19	ear) 9.60 916 I	rthplace (State or Foreign country) OWA
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location		-		10d. Inside City Limits
	Mary Inche	to	Maryland Baltimon	re	Cato	onsville				1 □ Yes 2 No
	with the	Funeral Director	100 Street and Number 719 Maiden Choice	Lane-St.C	harles #	10f. Zip Code 1119 21228		10g	Citizen of What C	ountry?
	death	nerai	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of H			14. Race - Am Black, Wh	
900	72 hours efter death with the Maryland natural; or teme 23a or 28a-f ehow dical Examination in the motified at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠ Yes 2 □ N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 🛣 No	Specify:			White
5-0	72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>		Decedent's Usual Occup Give kind of work done	during most of wor	king 16	b. Kind of Business	s/Industry
121	within ene. then	ошо	Elementary/Secondary (0-12)	College (1-4or 5- 5+	+)	life. DO NOT use retired Litary Off:	•		Military	
D	Hygie other	Be Co	17. Father's Name (First, Middle, Last)			illeary offi		ne (First, Middle, Ma		
lan	should be filed within and Mentel Hygiene. marked other than imatic event, the Mentel than the matic event.	To B	Robert T. Burns				Blanche	Diehl		
Maryland 21215-0036			19a. Informant's Name/Relationship (7 Nelle Burns	ype, Print) Wife	19b.	Mailing Address (Street Maiden Cho				
Baltimore,	permit. Peges 1 and 2 Depertment of Health a Important: If Item 27 It eny Injury or other tre		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify		cemetery	Disposition (Name of crematory or other place on National		Date 20 20 Ar	c. Location - City o 1 ington,	
Balti	permit. I Depertm Importal eny Inju		21. Signature of Funeral Service Licen		in Lis	22. Name and Addre	ss of FacilitySte	rling Ash Catonsvill Venue; Cat	ton Schwa	ab Witzke
Г			23a. Part1. Enter the disease, or comp	plications that caused	the death. Do no					Approximate Interval Between
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each lin	Preu	nonio				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of	200				
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	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			,				
o,	ficate be executed physicien and s the burial-transit	Exa	resulting in death) Last	Due to (or as a	a consequence of	i):				
38760,	cate by	dical		d						
•	ding p		IF FEMALE:	23c. If yes, outcome of	of preopancy	100			224 Day 444	B
Box	death certific e attending p od for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth :	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	'		23d. Date of de Month	Day Year
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S, D	res thet the de signed by the a be detached f	by P	Part II. Other significant conditions co	entributing to death bu	ıt not resulting in	the underlying cause giv	en in Part I.			to the cause of death?
ord	w requir been si should I							1 ☐ Yes	(≥(□ No 3□ F	Probably 4 ☐Unknown
Division of Vital Records,	The law requires thet the site has been signed by the page 2 should be detache	Completed						24a. Was an autopsy performe	d? death?	utopsy findings available completion of cause of
ita	ortifice ctor. 1	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th Check only one		
<u>ک</u>	Physicien: rthis certific ral director.	၉	1 ☐ Yes 3 € No	Hospital:			Nursing H	ome 5 Residence		ecify)
sion (Attending Property of death.	Certification:	27. Manner of Death Natural 5 Pending a Accident investigation			jury Wor	yat k? Yes 2 ∐No	28d. Describe how	injury occurred	
Divis	al or Att	Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc		m, street, factory, office		28f. Location (Stree City or Town,		Rural Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours elter death. To the Funeral Director: Aller this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier Certifying Physics (Check only one)	ysician: To the best of liner: On the basis of and manner sta	examination and	death occurred at the tir /or investigation, in my o	ne, date and place pinion, death occu	, and due to the caustred at the time, date	se(s) and manner a a and place, and du	as stated. re to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	MD		29c. Licens	e number	290	Date signed (Mor	3 (006
15	+		30. Name and address of person who	7	eath (Item 23a) (T	Type, Print) Choile	and (9	Juns v.16	May	1
	Sta	ite	31. Date filed (Month, Day Year) 7	32 Registra	ır's Signature	Conti				
	Registrar									

06-07434 Michael Blake

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2151.1

		l-For State Registrar	Certificate of Death	Reg. No. 2005 31341
Physicia edical Examir	ın/	1. Decedent's Name (First, Middle, Last) Michael Blake		2. Date of Death Month October 2, 2006 3. Time of Death 1812 hrs
		4a. Facility Name (if not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age 1 12 M 2 F	(In yrs. last birthday) If Under 1 Year If Under 24Hrs	- Foreign
eath with the Maryland items 23a or 28a-f show any ust he notified at once.	uneral Director	MD NIA 10e. Street and Number 625 Cator Avenue 11. Marital Status 1 Never Married 2 Married Armed Forces?	Oc. City, Town or Location Bathnore 10f. Zip Code 21218 Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	
16 n 72 hours after d nan "natural", or ical Examiner m	Completed by Fun	Widowed 4 Divorced of Dates: 15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+1)	during most of working life. DO NOT use reti	
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	o Be Cor	17. Father's Name (First, Middle, Last) Norman Blake 19a. Informant's Name/Relationship (Type, Print)	18 Mother's Name 19b. Mailing Address (Street and Number or	Po (First, Middle, Maiden Surname) O C I Hin Rural Route Number, City or Town, State, Zip Code)
ore, MD 2 s. 1 and 2 shou of Health and D If item 27 is r her traumatic	۲	Sonya Lewis / Ex - Wife 20a. Method of Disposition 1 MBurial 2 Cremation 3 Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)	nue Seven MD 21144 Date 20c. Location - City or Town, State
Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumat		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Trinity Cemetery 10	unoral services
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. Immediate Cause (Final disease a. Cocaine into	he death. Do not enter the mode of dying, such as cardiac o	or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, b.		
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
760, cate be executed physician and the burial - transit	edical Ex	d	.27,28a-f,perME,g860, 10/26/06 TT	
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcom 1 Live birth 4 Pregnant at t	e of pregnancy 2 Fetal death 3 Ectopic pregn	23d. Date of delivery
P.O.	by	Part II. Other significant conditions contributing to death	but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
tal Records, cian: The law require certificate has been si ector, page 2 should be	Completed		25 Place of Death (Check	autopsy performed? 1
F Vital Physician: r this certif	To Be	25. Was case referred to medical examiner? 1 V Yes 2 No 100 No. Data of Initial Control		ng Home 5 Residence 6 Other:
Division of tall or Attending Ptrs after death al Director: After led in by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injure 28a. Date of Inj	ear)	unknown 28f Location (Street and Number or Rural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		Suicide S Could not be determined (Specify) Un	tion Memorial Hospital knowledge, death occurred at the time, date and place, an	orTown State) 201 E. University Parkwa Baltimore, MD
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of exam and manner stated. 29b Signature and title of certifier	nination and/or investigation, in my opinion, death occurred 29c, License number	at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of de	O.C.M.E.	October 3, 2006
	tate	Theodore M. King, Jr., MD. Assistant M	edical Examiner 111 Penn Street, Baltimo	re, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ambrosine 11:53 PM Caruth 2006 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA memoria Da nore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1 M 2 KF Months 215-23-0261 ec. Director Trinidad Usual Residence of Decedent 10c. City, Town or 2 ocation 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? ö , 23a c Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 'natural", or Bla 1 ☐ Yes 2 XÑo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene important; If Item 27 is marked other than any Injury or other traumatic event, the Me once. College (1-4or 5+) Elementary/Secondary (0-12) Dome 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Baptiste enwick PIUllus heo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wentworth Caruth 4211 Balto, md, 2120 husband 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ansdrund 4 Donation 5 Dother (Specify) 22. Name and Address of Facility of Funeral Service License Fran 23a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or near failure. List only one cause on each line. Sovice Balto ind. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Mylaid Leukemia weak /Medical Due to (or as a consequence of): Examiner End Stage R. Due to (or as a consequence of) Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 M Physician/Medical Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed Bacterenia ZWKS Due to (or as a consequence of): physician as the burial-1 Division or Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Wabeles Hellitus - Type IF 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hapertension autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours arer dearh.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OPPBCH67A 10/04/06 Burn M.D

Registrar

State

Baltimore,

MO 21218 - Or. Danielle L. Brow

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parkway Bo

201 East University

31. Date filed (Month, Day, Year)

Jamelle Maurice Carter

Please Type or Print in Black Indelible Ink

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State of	Marylan	id / Depar	tment of H	ealth and I	Mental F	Hygien

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odinolo Macrico		- For State Registrar	Cert	fificate of Deat			2006	3 5 4
Physicia Medical Exami		Decedent's Name (First, Middle,Last)	Maurica		Cartor	2. Date of Death Month September	Day Year	Time of Death 2311 hrs
		Jamelle 4a. Facility Name (if not institution, give street	Maurice and number)	4b. City, T	Carter own, or Location of De		4c. County of Death	20171110
Funeral		Sinai Hospital 5. Social Security Number 6 Sex	7, Age (In yrs. las	Baltin	nore er 1 Year I If Under 24	4Hrs R Date of Birth	(MM/DD/YYYY) 9 Birt	nnlace (State or
Director		579-17-9426 1 XM 2		Month		Min. 11 1	Foreign	
* any	ı	10a State 10b. County	* * * * * * * * * * * * * * * * * * * *	Town or Location				10d. Inside City Limits
yland 1-f shov	ģ	MD NA 10e. Street and Number	Ba.	ltimore	Code	140	Citizen of What Coun	1 X Yes 2 No
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	5	4115 Fords Lane		101. 210	21215	10	U.S.A	
th with	eral	11. Marital Status 12. W	as Decedent Ever in U.S		nt of Hispanic Origin? y Cuban, Mexican, Pu		14. Race - Americ White, etc.	
iter dea		3 Widowed 4 Divorced of Yes,	Yes 2 No		X No specify	,		ack
hours a	ed b	15. Decedent's Education (Specify only high		16a Decedent's Usual			16b. Kind of Business/Ir	ndustry
215-0036 be filed within 72 hours after death with the Maryland ntall Hygiene riked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once.	Completed by	3013	llege (1-4 or 5+) na	Stude		,	School	
21215-0036 build be filed within 7 Mental Hygiene marked other than ic event, the Medica		17. Father's Name (First, Middle, Last)				ame (First, Middle, M	aiden Surname)	
2127 uld be uld be Mental marke		James Banks 19a. Informant's Name/Relationship (Type, Pr	int)	19b. Mailing Address		Carter or Rural Route Numb	er, City or Town, State,	Zip Code)
MD nd 2 sho lith and m 27 is aumati		Jean Carter-Mothe		4115 For	ds Lane,	Baltimo	re, Md 2	1215
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21	noval from State cr	lace of Disposition (Nar rematory or other place)			20c. Location - City or	
Baltimore, permit. Pages I a Department of He Important: If ite	}	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee)	butus Mem 22. Name and	Address of Facility	0/6/06	Arbutus,	Md
	4	23a Part Enter the disease, or complication	mes	March 4300 W	F/H West abash Av	e, Balti	more, Md	21215
Physician /Medical		failere. List only one cause on each line	s that caused the death. I hot Wound to Head		or dying, such as cardi	ac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner			(or as a consequence of)					
NJ+	Jer		(or as a consequence of));		· ·		
11	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(or as a consequence of)):		·	-	
760, cate be executed physician and he burial - transit		d d	NDED.		***			
760, icate be e physicial	Medical		NDED If yes, outcome of pregna	ancv			23d Date of delivery	
687 certifica nding p		23b Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of dea	2 Fetal death	3 Ectopic pre	egnancy		ay Year
P.O. Box 68 that the death certify ned by the attending detached for use as	Physician	1 Yes 2 No 9 Unknown 9	Unknown	5 Other (Spe	-			
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burnal - transi	ğ	Part II. Other significant conditions contril	outing to death but not res	sulting in the underlying	cause given in Part I		acco use contribute to t	
cords, P.C. law requires that has been signed should be dete	Completed					24a. Was ai autops		opsy findings available ompletion of cause of
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ital Re(ician: The secriticate	å	25. Was case referred to medical examiner? Hospital	1 Inpatient 2		26. Place of Death (Ch		esidence 6 Other	
Division of Vital Records, Hospital or Attending Physician: The law requires after death Funeral Directors. After this certificate has been sitely filled in by the funeral director, page 2 should be	2	1 ✓ Yes 2 No 27. Manner of Death 2B	a Date of Injury	28b. Time of Injury	Bc. Injury at Work?	2Bd Describe ho	w injury occurred	
ivision or Attendi after death Director:	catio	2 Accident Investigation	ep 30, 2006	FOUND: 2232 hrs	1 Yes 2 ✔ No			
Divi	Certification:	Suicide Could not be	Be. Place of Injury - At hor Specify) Local Stree		office building, etc.	or Town, Sta	reet and Number or Rur ate) f Oswego Avenue	
		29a. Certifler 1 Certifying Physician: To				and due to the cause	(s) and manner as start	ed.
To the within To the complete	Medical	one) 2 Medical Examiner: On the and m 29b. Signature and title of pertifier	e basis of examination an anner stated		opinion, death occurr	red at the time, date a	nd place, and due to the 29d Date signed (Mon	
		4 ml	1/		O.C.M.E.		October 1, 2006	,,,
		30. Name and address of person who comple Jack Titus MD. Deputy Chief	ted cause of death (Item 2	,	et, Baltimore, MD	21201		
St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signatur		z, Daninoie, ML			
Danie		OOT 0 5 2006	1980 Duga 3 252	A 6 1 5 25 C				

		•	For State Registrar	State of	Marylan	•	artment of H				giene	006	31544	
	Physici	2.0	1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea		JseY	3. Time of Death	
	/Medic		Ossie	Sam			Crawf			IO Nonth	O 2 Day	2006		
	Examin	er	4a. Facility Name (If not institution		er)		4b. City, Town, or		of Death			4c. County of Death Baltimore		
			Gilchrist Hos 5. Social Security Number		Age (In yrs.	last hirthday)	TOWS	If Under	24 Hrs.	8 Date of Birt				
	Funeral Director		212-42-7769	1 ½ M 2□F	61	Yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Day 01 2		5	thplace (State or Foreign ountry) MD	
			Usual Residence of Decedent				1	1		UI Z	2 7	<u> </u>		
	how		10a. State 10b. County			y, Town or Lo							10d. Inside City Limits	
	Be-fo	ecto	MD NA	4	В	altim							1 X Yes 2 No	
	with ti	Funeral Director	10e. Street and Number	ee paad a	nt Di		10f. Zip Code	1215			-	en of What C	•	
	eath Tunt	erai	3607 Fallsta:	12. Was Decede						cify Yes or No		4. Race - Am		
(0	r iten	F	1 XNever Married 2 Marr	Armed Force	es?		Was Decedent of Hi f Yes, specify Cuba	n, Mexicar	n, Puerto I	Plican, etc.) Black, White				
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23e or 28e-f ehow tha Madical Examinar must be notillied at	Ď.	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	os:		I□Yes 2√√ No	Specify:			5	Specify:	Black	
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an	Ossie S. Crawford Sr. Ossie S. Crawford Sr.													
Maryland	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura PERSON Beverly Crawford Cruz 8313 Arbor Station													
							Way,	Balt	o, Mo	21234				
ore	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 10/					ate		ation - City or						
Ë						/14/06	Ran	dalls	town, Md					
Bal	Depermit Depermit Impor eny in	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marchf/H West 4300 Wabash Ave, Baltimore						e, Mo	21215					
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death h line.	h. Do not ent	er the mode of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death	
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Вох	etten etten I for u	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth	n 2 ☐ Feta t at time of de	Ideath 3	Ectopic pregnancy Other (specify)				23	3d. Date of de Month	Day Year	
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of Vital Records,	e law ri has be je 2 shi	Completed								24a. Was		prior to	utopsy findings available completion of cause of	
<u>~</u>		Son									med? 2 No	death?	2 □ No	
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of	Phys this aldi	은	1 Yes 2 No	1 □ Inp		ER/Outpatien 28b. Time of		4 1140		ne 5 Resid			city) HOSACE	
27. Manner of Death 28d. Date of Injury 28d. Describe how injury occ (Month, Day Year) 28d. Describe how injury occ (Month, Day Year) 28d. Describe how injury occ (Month, Day Year) 1							Occumen							
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	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifyin (Check only one)	ng Physician: To the be Examiner: On the basi and manner	s of examina	wledge, death ition and/or inv	occurred at the time restigation, in my op	ne, date ar pinion, dea	nd place, a ith occurre	and due to the o	ause(s) a date and p	nd manner a place, and du	s stated. e to the cause(s)	
	To t To tl	Σ	29b. Signature and title of certifie	1	n		29c. License	number	_		29d. Date	signed (Mon	th, Day, Year)	
,	Λ		1/1/ 1/m	they the	Ky,	uro	Print) V. Charle	290	7	(Jet	eber 2	-, 2006	
	(1)		30. Name and address of person	who come eted cause	of dear (Item	n 23a) (Type,	Print)	C	0	2 11.	MAI	7.	2000	
	Sta	J.	31. Date filed (Month, Day, Year)	19 (1) 132 Ran	1 (6 istrar's Signa	iture A	y. Urent	co Ut	-	couro.	ruca			
	Registr		OCT 0 5 20	106	di di di	A STATE OF S	San							
-				.52										

06-07444 Scott Campbell

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

cott Campbell			ificate of Death		No 200	6 3154
Physicia ledical Exami	an/	1. Decedent's Name (First, Middle,Last) Scott Matthew Campbell		2. Date of Death Month October 3,	Day Year	3. Time of Death 0541 hrs
eulcai Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D		4c. County of Death	
		6132 E. Pratt St.	Baltimore st birthday) If Under 1 Year If Under 2	4Hrs R Date of Birth	n/a	hnlace (State or
Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. las 4.3		Min. Oct. 20	Foreig	
any	ł	Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	own or Location			10d Inside City Limits
ž ,	5	114.	Baltimore			1 X Yes 2 No
e Maryla or 28a-f	Director	10e. Street and Number	10f. Zip Code 21224	100	Citizen of What Cour	ntry?
with the	a D	6132 E. Pratt Street 11. Marital Status 12. Was Decedent Ever in U.S	. 13. Was Decedent of Hispanic Origin?	?-(Specify Yes or No-	14. Race - Ameri	can Indian, Black,
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tenth and Mental Hygiest tenth and Mental Hygiest tenth and "matural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	Armed Forces? Armed Forces? The second of	If Yes, specify Cuban, Mexican, Pu	uerto Rican, etc.)	White, etc.	.te
5-0036 led within 72 hours aff tygiene other than "natural" the Medical Examine	d by	or Dates:	16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		16b. Kind of Business/I	ndustry
36 in 72 h hau "n lical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 years	disabled	5 10.11.54)	n/a	
d with ygiene other the Mec	E O	17, Father's Name (First, Middle, Last)		lame (First, Middle, M		
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be	Robert E. Campbell, Sr.		aine Lear		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 perment. Health and Mental Hygiere Important: If item 27 is marked other than injury or other traumatic event, the Medical	٩	19a Informant's Name/Relationship (Type, Print) Lorraine Pugaczewski/mother	19b. Mailing Address (Street and Numbe 337 Pintail Drive,			
e, N I and 2 Health Fitem 2		20a. Method of Disposition	lace of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
Pages Pages nent of ant: Il		4 Donation 5 Other Specify: Mt.	. Zion United thodist Ch. Cem.	10/7/06	Bel Air, N	
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	1	21 Signature of European Service Libensee	22 Name and Address of Facility Schimunek Funera	al Home of	Bel Air,	Inc.
Physician	\rightarrow	23a Part I. Enter the disease, or complications that caused the death.	Do not enter the mode of dying, such as card	Road Be L	st, shock, or heart	Approximate Interval Between Onset and
/Medical *xaminer	(erosclerotic cardiovascula	ar disease		Death
No.		or condition resulting in death) Due to (or as a consequence of) b.):			
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Division of Vi Hospital or Attending Physi 24 hours after death Funeral Director: After this	Certification	3 Suicide 6 Could not be determined (Specify)		or Town, Si	tate)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge one) 2 Medical Examiner: On the basis of examination and manner stated.				
£ 8 0	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	
		Theodhe M. King JR.	and). O.C.M.E.		October 3, 2006	····
		80. Name and address of person who completed cause of death (Item Theodore M. King, Jr., MD. Assistant Medical E		imore, M D 21201		
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	ire hands	-		
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	Dhusisi		1. Decedent's Name (First, Mi	ddle, La	st)					2. Date of De Month	ath Day	Year	3. Time of Death
0	Physici /Medio		Lertilak Cho	ksav	wat						er 27,		1:13 PM M
<i>)</i>	Examin	er	4a. Facility Name (If not institu			umber)		4b. City, Town, o	r Location of Deat	th	4c. County	of Death	
- ,			Shady Grove 5. Social Security Numberum			7 6-0	(In the Inch hinds to	Rockvil // If Under 1 Year				gomer	
	Funeral Director		5. Social Security Number UT		sex 1 □ M 2 X TF		(In yrs. last birthda 26 Yrs.	Months Days	Hours Min.	. (Month, Da	y, Year)	Coun	
			Usual Residence of Decedent	i			20			Dec 22,	1979	Inai	.land
	yland		10a. State 10b. Cou	nty		1	Oc. City, Town or	ocation				1	0d. Inside City Limits
	Mar.	tor	MD Mon	gom	ery		North P	otomac					1 ☐ Yes 21 No
	or 28	lrec	10e. Street and Number		-			10f. Zip Code			10g. Citizen of V	Vhat Cour	itry?
	th wi	Funeral Director	122 Swanton I	ane				208	378		Thai1	and	
	r dea	ne	11. Marital Status		12. Was De Armed I		er in U.S. 13	. Was Decedent of H	lispanic Origin? (S	Specify Yes or No		e - Americ ck, White,	
36	or It	by Fu	1X Never Married 2 ₪ N		1 XYes	2 No		1 ☐ Yes 2 🗓 No	Specify:		Specify		sian
Ş	hour tural	d b	3 ☐ Widowed 4 ☐ Divord		Year or	Dates:	10- 0						
Ÿ	n 72	Completed	15. Deced (Specify only hig	hest gra	ade completed		(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of wo	orking	16b. Kind of Bu	isiness/inc	dustry
7	withi Bone.	mc	Elementary/Secondary (0-12 unk		College unk	(1-4or 5+)		ı pair	-,		self e	mn1ox	hor
Ö	Hygin Hygin		17. Father's Name (First, Midd	_				pull	18. Mother's Na	me (First, Middle,			Cu
<u>a</u>	lid be lental ked i	To Be	Lerchai Chok	saw	at				Phikun	Choksawa	t		
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or Items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	_	19a. Informant's Name/Relation				19b. Ma	ling Address (Street	and Number or R	ural Route Numbe	er, City or Town,	State, Zip	Code)
Σ	alth alth 27 1,27 1, or tra		Phikun Choksa	wat/	mother	•	337- T-SL	258 Ban - T IA A Muan	hai Gran Khon K	der Mitt aen. Tha	raparp F	9999	
Baitimore,	of He		20a. Method of Disposition		75	a. .	20b. Place of Dis	oosition (Name of amatory or other pla		Date	20c. Location -	City or To	wn, State
Ĕ	Page nent can int: If		1 Burial 2 Crematic	n 3∟ <i>(Specil</i>	JRemoval from	n State tate	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		l,			
<u>=</u>	permit. Pages 1 Department of H Important: If Its eny Injury or ot		21. Signature of Euneral Servi				ctor	22. Name and Addre	ss of Facility	J 655 TT	D - 1 + 4		
n —	8978	10 1	Juni	1		100	Ž	tate Anat altimore,	$\stackrel{\text{MD}}{\text{MD}}$ $\stackrel{\text{BO}}{2}12$	01 033 W.	baltimo	ore S	treet
			23a. Part1. Enter the disease shock, or heart failure. L	or com	plications that	caused the	e death. Do not e	nter the mode of dyir	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition		_	Ohst	ructive l	Hydrocepha	1 v			1	Onset and Death week
	/Medical		resulting in death)		Due to		consequence of):	туштосери.					week
	Examiner		Sequentially list conditions		b		in vent	icle				υ	ınknown
	D is	Ine	if any, leading to immediate cause. Enter Underlying	1	Due to	o (or as a	consequence of):						
	and -tran	Examin	Cause (Disease or injury that initiated events resulting in death) Last	1	C. Due to	0 (05 35 3 4	consequence of):						
8/60,	cate be executed physicien and the burial-transit	回		ı	Ode ii	o (Oi ais ai t	sunsaquarica or).						
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×	death certifi e attending id for use es	Iclan/Me	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, o	utcome of	pregnancy				23d Dat	e of delive	.nu
ğ	atter	clar	in the past 12 months?		1☐Live	birth 2	☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	1		Moi		Day Year
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s, T	requires that the death certifeen is greed by the attending nould be detached for use e	by PI	Part II. Other significant cond	ltions o	contributing to	death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use conti	ribute to th	e cause of death?
ğ	quire on sig uid biu									1 🗆 ۱	res 2⊡•No	3 Prob	abiy 4 □Unknown
Hecord	> 0.4	Completed								24a. Was		Nere autor	osy findings available
	0 5 0	E									rmed?	prior to con death? □ Yes	npletion of cause of
VITal	ician: The certificate ector, pag	0	25. Was case referred to med	cal	5	5			28. Place of Dea	1 ☐ Yes ath (Check only o		105	2010
	Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2 ☐ No	1	Hospital:	npatient	2 ER/Outpati	ent 3 DOA Oth		Home 5 ☐ Resid		ar (Specify	,)
n O			27. Manner of Death 1 □ Matural 5 □ Pen	dina	28a. Date (Mo	e of Injury onth, Day Y	(ear) 28b. Time				now injury occurr		
UIVISION	r Attending er death. rector: After by the funer	att	2 ☐ Accident Inve	stigation					Yes 2 □ No				
≦	or Atl fter d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined	28e. Plac	ce of Injury ding, etc.	- At home, farm, s (Specify)	treet, factory, office		28f. Location (S City or Tox	Street and Numbern, State)	er or Rura	l Route Number,
_	pltafor		-/										
	Hos 24 ho Fun Itely f	edical	29a. Certifier 1Carti (Check only 2 Medic	ai Exar	niner: On the	basis of e	kamination and/or	ith becamed at the ti- nvestigation, in my o	ne, date and plant pinion, death occu	and due to the urred at the time,	tauso(e) and his date and place, a	inner at et and due to	the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Med	29b. Signature and title of cert	fies	and ma	nner state	Š	29c. Licens	e number		29d. Date signed	(Month	Day, Year)
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•			30. Name and address of pers	חת שלות	completed as:			-	4010T	7	SI I CIVI	シスへ	29,2066
			Ajit Phil					kville,MD	20852				
	Sta	te	31. Date filed (Month, Day, Ye	ar)			s Signature		40074				
	Registr	_	OCT 0 5	200	10	J. Ball and	s Signature	Veled					

06-07053

Please Type or Print in Black Indelible Ink

Physician/edical Examiner A	3. Time of Death
4a. Facility Name (if not institution, give street and number) 2107 Orems Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 4b. City, Town, or Location of Death Essex If Under 1 Year If Under 24Hrs. 8. Date of Birth (Months Days Hours Min.	
2107 Orems Road Essex Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (Months Days Hours Min.	
Months Days Hours Min	Baltimore County
11A W 2 F 30 11S. P1Ay 22,	MM/DD/YYYY) 9 Birthplace (State or unk Foreign Country)
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d Inside City Limits
	1 Yes 2 X No
The Bartimore Essex 10f. Zip Code 10g. Grant 10g.	Citizen of What Country?
MD Baltimore Essex 106. Street and Number 107. Zip Code 109. Cip Code	USA 14. Race - American Indian, 8lack,
The second of Hispanic Origin? (Specify Yes or No-Armed Forces? Unk 1 Never Married 2 Married 1 Yes 2 No No No-Armed Forces? Unk 1 Yes 2 No No No-Armed Forces? Unk 1 Never Married 2 Married No	White, etc.
3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify or Dates: 1 Yes 2 No specify: 1 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work doneun) 16	Specify white b. Kind of Business/Industry unk
Security of the first of the fi	dik
To serious properties of the serious propert	en Surname) unk
To you had be seen as well as the second of	en Surname) UIIK
The property of the control of the c	, City or Town, State, Zip Code)
Use the control of Disposition (Name of cemetery, Date 20a. Method of Disposition (Name of cemetery, Date 20b. Place of Disposition (Name of cemetery))	21201 Oc. Location - City or Town, State
S S S S S S S S S S S S S S S S S S S	
21. Signate of Funeral Service Licensee Ronal Id S. Wada Director State Anatomy Board 655 W.	Baltimore Street
Physician 23a. Pat I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the such a	shock, or heart Approximate Interval
Medical Immediate Cause (Final disease A. Hypertensive athersoclerotic cardiovascular disease Immediate Cause (Final disease Immediate (Final disease (Fin	8etween Onset and Death
or condition resulting in death) Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
AMENDED #23a,PII,27,perME,C860, 10/26/06 TT #23a,PII,27,perME,C860, 10/26/06 TT #24 april 1	
AMENDED AMENDED AMENDED #23a,PII,27,perME,G860, 10/26/06 TT #23a,PII,27,perME,G860, 10/26/06 TT 23c. If yes, outcome of pregnancy	23d. Date of delivery
23b Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobac	Month Day Year
O to	
Diabetes Mellitus	co use contribute to the cause of death? ! No 3 Probably 4 Unknown
Z4a Was an autopsy performed to the state of the state o	24b. Were autopsy findings available prior to completion of cause of
performer 1 ✓ Yes 2 V Yes 2	d? death?
25. Was case referred to medical example of the control of the con	id C. [4] ON O
The splication of the splicati	idence 6 🗸 Other: Scene injury occurred
C in the state of	
24a Was an autopsy performer to the properties of the properties o	et and Number or Rural Route Number, City)
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) one 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated. 29b. Signature and title of certifier 29c. License number 29	d Date signed (Month, Day, Year)
Calillas Al O.C.M.E. S	eptember 19, 2006
30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	

State of Maryland / Department of Health and Mental Hygien 2006 31548 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** September 20, 2006 3:10 PMM John Leonard Creel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Queen Anne's Stevensville 4 Monroe Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In vrs. last birthday) 6 Sex **Funeral** 1**∑**M 2□F Months May 4, 1943 Maryland Director 63 216-42-3323 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County rthan "naturel", or itema 23a or 28a-f show the Medical Examinat must be notified at 1 ☐ Yes 2√ No Director Stevensville MD Queen Anne's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4 Monroe Court 21666 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) construction 12 permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy important: if Item 27 te marked other eny injury or other traument. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Roselma Stewart Robert Hughes Creel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4 Monroe Court Stevensville, MD 21666 Eleanor Creel/spouse 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S Wade Director State Anatomy Board 655 W. Baltimore Street t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Baltimore, MD 21201 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cell 7 mos **Physician** Carcinoma metastatic /Medical Due to (or as a consequence of): **Examiner** fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting to day Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical А IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No sate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 100 director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; Division Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the ! 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 26, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 North Broadway, Baltimore MD 21231 Michael A. Carducci 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 0 0 6 31549 1- For Amend item#8, perFH, g860, 10/6/06 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Emily Francis Carlson 11:30 P ^M Oct. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent & Rehab. Ctr. Crofton Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, April 26, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Yrs. Director 98 318-22-3894 Michigan Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 la marked other then "natural", or Itema 23a or 28a-f show other treumatic event, the Mcdical Examiner must be notified at 1 ☐ Yes 2 🗖 No Directo Maryland Anne Arundel 0denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1023 Summer Hill Drive 21113 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or ther any injury or other treumatic event, the Medical Exemina-1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 à 1 Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own home House wife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ည George Stahovic Stephanie UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Ann Boyd/grand daughter 493 Peach Tree Court, Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1

Burial 2 □ Cremation 3 □ Removal from State * 4 Donation 5 ☐ Other (Specify) Holy Sepulchre 10, 2006 Alsip, IL 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.
1411 Annapolis Road, Odenton, MD 21113 21. Signature of Funeral Service Licenses menuc mode 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Aspiration Pneumonia /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Discuss of Injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the a 1 ☐ Yes 2 📉 No 9 Unknown 9 Unknown ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by Pe cate has been sig , page 2 should b Dementia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' certificate 1 🗌 Yes X No 1 Yes 2 **X**No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred After 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ۵ 4 Homicide hours after 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) October 4, 2006 D38958 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daljeet Sidhu 208 Crain Hwy., Glen Burnie, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature OCT 0 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygien [] [] [

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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year J. Ruth Clark 2, 2006 October 5:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Keswick MultiCare Center Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2804 215-05-7813 94 Yrs. Director Feb. Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23e or 28e-f show other treumatic svent, the Medical Examinar must be notified at Director Maryland N/A XXYes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3741 Keswick Road 21211 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXIII Specify: Specify. δ white 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Ilem 27 is marked other then any injury or other treumatic suent Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In own home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Levi Arbaugh Jessie Ella Pickett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan H. Wilhelm (niece) 3741 Keswick Road Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Pleasant Cemetery 10/6/2006 Gamber, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Licencee 22. Name and Address of Facility Burgee—Henss—Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracronial month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any learn, bin mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consistuence of physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetel death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 0 55truction 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ٩ 1 Inpatient 2 ER/Outpatient 3☐ DOA 28b. Time of 28c. Injury at Work? After t 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25205 and address of person who completed cause of death (Item 23a) (Type, Print) 6201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3014 W Graham J. Cusic, Sr. 0 2-006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HOSPito 59, note ankli 050 0 0 0 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 15 5. Social Security Numbe 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months **№** М 2□ F 217-03-7053 MD Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4520 Raspe Ave. 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status TYPes 2 No TYPes, Give Year or Dates: 42-46 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Baking 12 n/a Bread Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paul Cusic Laura Butterworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, M& Anne M. Wright/daughter 3051 Arizona Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 10/9/06 Catonsville, MD 21. Signature of Funeral 8-sylce Licensee Lemmon Funeral Home of Dulaney Valley, Inc.

10 W. Padonia Rd., Timonium, MD 21093

23a. Part1. Enter the diseas promplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximations Course (1975) 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition orat d resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Division of Vital Records, P.O. Box 68760 signed by the a id be detached f peed has To the Hospital or Attending Physicien: this

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Examine

Physician/Medical

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Completed

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Certification:

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day Year) 06

Funeral

Director

liem 27 is marked other than "neture!", or liems 23s or 28s-4 show other treumstic event, the Modical Examinar must be notified at

filed within 72 hours after Hygiene.

the Pages 1 and 2 should be filed informment of Health and Mental Hygientent; If Item 27 Is marked other

permit. Page Department of Importent: If any Injury or once.

Physician

/Medical

Baltimore,

with the Maryland

State Registrar

DHMH 17 Rev 1/2001

Director: d in by the

in 24 hours the Funeral Directory filled in

To the within

141

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

. 9000Franklingsquare prive Baltimore, MD 21237

29d. Date signed (Month, Day, Year)

3 06-07361 Please Type or Print in Black Indelible Ink Victor Lee Council State of Maryland / Department of Health and Mental Hygiene 2006 31552 1. For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ September 30, 2006 **Medical Examiner** 1208 hrs COUNCIL VICTOR LEE 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death University of Maryland **Baltimore** 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5 Social Security Number 6. Sex If Under 24Hrs. **Funeral** Director Months Days Hours 42 215-94-3077 August 3,1964 1X M 2 F Country) Usual Residence of Decedent any 10a. State 10c. City, Town or Location 10d Inside City Limits items 23a or 28a-f show ust be notified at once. 1 X Yes 2 No Md. Baltimore hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6618 Vincent Court #301 21215 United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or items 2 Armed Forces? 1 X Never Married 2 Married Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene
Unportant: If item 27 is marked other than "matural", o
injury or other trannalite event, the Medical Examinear. Specify: Black 1 Yes 2X No specify 3 Widowed Divorced f Yes, Give Year Š 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Comple Cook 12th Restaurant 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Lee Davis Freda Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvette McFadden / Sister 4333 Black River Rd. Gable, S.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery 10 - 7 - 06Clinton, Md. 4 Donation 5 Other Specify ure of Funeral Service Lice 22. Name and Address of Facility Capitol Mortuary 1425 Maryland Ave., NE Wash., DO onot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician /Medical Part I. Enter the disor complications that cau failure. List only one of use on each line Between Onset and Gunshot wound to head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last cian/Medical UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death 2 past 12 months? Pregnant at time of death 5

PA

Death

Year

October 2, 2006

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death

Physi	1 Yes 2 No 9 Unknown	9 Unknown	opes.iy,						
	Part II. Other significant conditions co	ontributing to death but not resulting in the under	ying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?					
d b				1 Yes 2 No 3 Probably 4 Unknown					
Completed	-		<u> </u>	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No					
Be	25. Was case referred to medical		only one)						
9	examiner? 1 Yes 2 No	pital: 1 🖊 Inpatient 2 ER/Outpatient 3	DOA Other Nursin	ng Home 5 Residence 6 Other:					
	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d Describe how injury occurred					
흵	Natural 5 Pending	Sep 30, 2006 0015 hrs	1 Yes 2 V No	Subject shot					
밀	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, street, fac	tory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City					
Certification:	Suicide 6 Could not be determined	(Specify) Local Street		or Town, State) 1408 West Baltimore Street, Baltmore, Md.					
29a Certifier									
Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated								
ĔΙ	29b. Signature and title of certifier		29c. License number	29d Date signed (Month, Day, Year)					

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

al Director:

within 2

2

State

Registrar

Tasha Greenberg MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

Pales .

30. Name and address of person who completed cause of death (Item 23a)

200 5

				partment of Health and M ertificate of Death		ZUUb	31553
	Physic		1. Decedent's Name (First, Middle, Last) Stephanie Drea		2. Date of Death Month October	Day Year 3, 2006	3. Time of Death 9:20 PM
	/Medi Examii		4a. Facility Name (If not institution, give street and number) Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death Bethesda y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Death Montgome 9. Birthpl Coun	ery lace (State or Foreign
	Director		219-48-1465 1 M 2 AT 60 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	Nov 1/,		achusetts Od. Inside City Limits
	ith the Marylan or 28e-f ehow	rector	Maryland Montgomery Beth	nesda 10f. Zip Code	10g.	Citizen of What Coun	1 ☐ Yes 2 ☒ No
	72 hours after death with the Maryland "natural", or Items 23a or 28e-f ehow Idical Examiner must be notified at	Funeral Director	6302 Friendship Court 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	20817 3. Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto		USA 14. Race - America	an Indian,
0036	72 hours after "natural", or it	þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ሺ No Specify:		Black, White, e	te
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fot yland	ould be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last) Andrew Drea	18. Mother's Name	e (First, Middle, Maid rette Bari	den Sumame)	
CKP (WC) 10/3/06 24 d: 20 pm 3altimore, Marylan	permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if tem 27 is marked other than any injury or other traumatic event, tha Magnee.			oiling Address (Street and Number or Rura D2 Pennydog Lane Si	lver Spri	ng, Maryla	nd 20902
RP (MC	nit. Pages estment of the ortant: If the injury or of		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Cr	rematory or other place) rematory Inc. 10/0	5/06 Ba	altimore,	
ગુર હ	Depe Impo any is		Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not e	22. Name and Address at Faculity Cremation Society 299 Frederick Road	Baltimore	e, Marylan	d 21228
68760,	ificate be executed American and Sphysicien and American and Street burial-transit	edicai Examiner	Immediate Cause (Final disease or condition resulting in death) List only one cause on each line. Due to (or as a consequence of):	struction Varian conver	, copiatory arrost,		interval Between Onset and Peath Day day en months
	that the death certifued by the attending detached for use a	by Physician/M		B⊟Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	ry Day Year
ords, P.	w requires that I been signed by should be deta	ted by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the	e cause of death?
al Reco	en: The law r lificete has be or, page 2 sh	Completed			24a. Was an autopsy performed	? prior to com death?	osy findings available apletion of cause of
Division of Vital Records, P.O. Box	ng Physick fter this cer ineral direct	Certification; To Be	25. Was case referred to medical examiner? 1 Yes No 1 Hospital: 2 EP/Outpatient 2 EP/Outpati	ent 3 DOA Other: 4 Nursing Hor of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in 28f. Location (Street	and Number or Rural	
Ö	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Cert	29a. Certifier (Check out) 2 Medical Examiner: On the basis of examination and/or in the basis of examination and/or	ath occurred at the time, date and place, a investigation, in my opinion, death occurred	City or Town, Sta	a(s) and manner as eta	ited,
•	To the I within 2 To the I complet	Med	29b. Signature and the bi certifier	29c License number		Date signed (Month, D	
	5		30. Name and address of person who completed cause of death (Item 23a) (Type G. Peter Pushkas MD 11510 Old Georg 31. Date filed (Month, Day, Year) Registrar's Signature		lle, Maryl	and 20852	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 5 2006 Registrar's Signature	de			

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artmen rtificate	t of H	ealth a Death	and M	ental Hy	giene Reg. No		3	554
	Physic	-	1. Decedent's Name (First, Middle, Las.	•						2. Date of De	eath Da	ıy Year	3. Tim	e of Death
	/Medi		Kathleen Marie						5	Septemb	er :	30, 200	6 3:	00 PM
	Examir	ner	4a. Facility Name (If not institution, give 5214 Anthony Ave	enue			Bal	timor	re			N/A	ith	
	Funeral Director		5. Social Security Number 6. Se 214-24-4845	7. Age (<i>In yr</i> s.)	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir Month, Da 09/26/	1929	9. Bill	thplace (Sta ountry) 'y lanc	ate or Foreign
	yland tow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation							10d. Insid	le City Limits
	a-f et	ş	Maryland N/A		Ва	ltimo	re						1)(2)	Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip	Code				10g. Ci	tizen of What C	ountry?	
	ath w	ral	5214 Anthony Ave			21206					J.S.A.			
396	d within 72 hours after death with the Maryland Jiene. r than "natural", or Rems 23a or 28a-f ehow the Medical Examinar must be mortified at	by Funeral	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Deced f Yes, spec 1 🗌 Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	>-	14. Race - Am Black, Whi	te, etc.	n,
21215-0036	2 hou	ted	15. Decedent's Edu	ıcation	16a. Deced	dent's Usua	l Occupa	tion			White 16b. Kind of Business/Industry			
215	within 7 ene. than "n	Completed	(Specify only highest grad	Colfege (1-4or 5+)	life. l	kind of wor DO NOT us	e retired)		of workin	g			ĺ	
	filed wi Hygien other th				Market	t Speci						ntal/Med	dical	
Maryland	2 should be and Menta le marked aumatic ev	To Be	17. Father's Name (First, Middle, Last) John Althoff							(First Middle en Sta		Sumame)		
lan		l	19a. Informant's Name/Refationship (7)									or Town, State,		
a)	s 1 and f Health item 27 other tr		Melvin M. Dziwuls 20a. Method of Disposition		1ace of Dispo	14 An	-	y Ave		Balt1	_	, Maryl		
nor	permit. Pages ' Department of h Importent: If Ite any injury or ot		1 XBurial 2 ☐ Cremation 3 ☐ F	Removal from State	eland	natory or ot	her place			/2006		ocation - City or		
altimore,	permit. Pa Departmer Importent Iny injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service (Alcens			. Name and		-		and the second second		timore, łarford		land
ä	Depa Depa Impo any is		Charls of Me	in the	L	eonar	d J.	Ruck	(, In	c. Ba	ltin	nore, MA		d 2121
	Physician // // // // // // // // // // // // //	dical Examiner	23a. Part1. Enter the disease, or compishock, or heart failure. List only of the shock, or heart failure. List only of the shock of the	ne cause on each line.	yence of):									Between nd Death
	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours alter death, within 24 hours alter death. On the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pre						23d. Date of de Month	livery Day	Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death but not resu	ilting in the ur	nderlying ca	use giver	n in Part I.		23e. Did t		use contribute to		of death?
Division of Vital Records,	he law re e has bee age 2 sho	Completed								24a. Was autop perfo		24b. Were au prior to death?	utopsy findir completion	igs available of cause of
ta	lysicien: The is certificete hadirector, page	ø	25. Was case referred to medical					26 Place	of Death	1 Yes	2 No	1 🗆 Yes	2 □ No	
<u>=</u>	Physici this cer al direc	To B	examiner? 1 Yes 2 No	lospitaf: 1 Inpatient 2 1	ER/Outpatien	3 DO/	Other			411		6 □Other (Spe	cifv)	
0	ng Pt fter th	ä	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28	c. Injury a			d. Describe I				
S	tendin leath. tor: Af the fur	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗀 Y	es 2□N						
DIV	Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the	Certification;	4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify)	me, farm, stre	et, factory,	office		28	3f. Location (S City or Tox	Street an vn. State	d Number or Ru)	ural Route N	lumber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my knowner: On the basis of examination and manner stated.	vledge, death ion and/or inv	occurred a estigation,	t the time in my opir	, date and nion, death	place, ar	nd due to the	cause(s) date and	and manner as place, and due	stated.	6e(s)
	To the within 2 To the complet	X	29b. Signature and title of certifier	21		29c.	License	number			29d. Dai	te signed (Mont	h, Day, Yea	r)
	1		Yaul A	du-p; 172			DI	658	7		0	90 Bur	2.7	006
	H		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, F	Print)		C.1		· -	-	_ ^	110	, ,)
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	01	10	J 70	156	471	لدسلا	300-10	U L	1004
1	Registra		007.0.5		K	Court	9							

DHMH 17 Rev 1/2001

			For State Registrar		State	of Ma	-	partment of F ertificate of		Menta	l Hygiene	$Z \coprod U$	3155	55
Phy	sicia	ın	1. Decedent's Name (First, Mi							2. Date of Death Month Day Year 3. Time of Death 4:38 Pm				
	edic min		Anna 4a. Facility Name (If not institu		e Deit			4b. City, Town, o	or Location of Dea			. County of De		
LAC			Union Memo	ria	al Hos	pita	al		imore			n/a		
Fune Direc			5. Social Security Number 214-24-7228		Sex I□M 2⊠TF	7. Age	(In yrs. last birthda 78 Yrs.	Months Days	Hours Min	n. (Mor	of Birth oth, Day, Year)	9. B 1927 E	irthplace (State or Fo Country) Delaware	reign
Pu &	663		Usuel Residence of Decedent 10a. State 10b. Cou	atu.			10c. City, Town or	Location					10d. Inside City Li	imite
Maryla f sho		ō	MD 100. God	•	Baltimon		Grani						1 ☐ Yes 2X	
r 28a-		irect	10e. Street and Number					10f. Zip Code			10g. Cit	izen of What (Country?	
th with		a D	10030 Davi	s Av	æ.				21163		Uni	ted Sta	ates	
ile, INICAL Y ICALID A LATE 13-0050 S 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-f show with status of the status.		by Funeral Director	11. Marital Status 1 □ Never Married 2004 3 □ Widowed 4 □ Divor		Armed F	s 21∑No Give 1 ☐ Yes 25☐tNo Specify:			Specify Yes irto Rican, e	ncify Yes or No-Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White				
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Athin 7		Completed	Elementary/Secondary (0-1	Ť	College		·)	DO NOT use retire	during most or we	UKING	Co	-d-1 C	a anna i tara Na	l m
filed w			12th 17. Father's Name (First, Midd	le, Last)		5	upervisor	18. Mother's Na	ame (First, i			ecurity Ad	HII.
Mental Hygiene		To Be	George								la Mae			
1 and 2 should Health and Men 27 Is marke		19a. Informant's Name/Relationship (Type, Print) William W. Deitz husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 10030 Davis Ave. Woodstock, MD 2116										21163	Zip Code)	
Peges 1 and the ment of He month of He mon			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Mem. Park Oct. 9, 2006 Sykesville, MD											
permit. Peges Department of Important: If Its	Suc		21. Signiture of Funeral Service License: 22. Name and Address of Facility Burrier-Oven Funeral Home & Crematory, PA 1212 W. Old Liberty Read Winfield, MD 21784											
			23a an1. Enter the disease shoo or heart failure.	or com	plications that	caused each line	ne death. Do not e	nter the mode of dyi	ng, such as cardia	ac or respira			Approximate Interval Between	
Physici /Medic	_	Ì	mmediate Cause (Final disease r condition resulting in death)		a. Non			m myoc	ardial	mfa	rction	n	Onset and Deat	5
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ficate be executed physicien end		dicai Ex	resulting in death) Last	l	d. Cor	or as a	consequence of):	tery o	liseas	e			13 yea	15
entifica ling ph	200	0	IF FEMALE:					/	3	-				
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quires that n signed b		<u>۾</u>	Part II. Other significant cond	itions	contributing to	death but	t not resulting in the	underlying cause gr	ven in Part I.	236			to the cause of death	
		Completed						·			i. Was an autopsy performed? Yes 212 No	prior to death?		iable e of
ician: The	2	Be	25. Was case referred to med examiner?	ical	Hospital			1 04	26. Place of De	eath (Check	only one)			
Physical Phy	5	<u>و</u>	1 Yes 2 No 27. Manner of Death		Hospital: 1 28a. Date	npatien of Injury		ent 3 DCA		-	Residence		ecify)	
Et : Afte		tion	1 Natural 5 Per	ding stigatio	(Moi	nth, Day	Year) Injun	Wo	rk?]Yes 2 □No	200. 200.	scribo now inju	ry occurred		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Fundal Director: After this certificate has commissed in his the financial director mans a	2	Certification:	3 ☐ Suicide 6 ☐ Co	id not b rmined	200. Flac	e of Injur ling, etc.	y - At home, farm, (Specify)	street, factory, office		28f. Loca City	ation (Street ar or Town, State	nd Number or I	Rural Route Number,	
he Hospif in 24 hour he Funera	Diagram A	edical	29a. Certifier 1 Certi (Check only one) 1 Medi	ying Pl	miner: On the	e best of pasis of e	examination and/or	ath occurred at the ti investigation, in my	me, date and place opinion, death occ	ce, and due	to the cause(s time, date and) and manner a d place, and du	as stated. ue to the cause(s)	
To t To t	3	2	29b. Signature and title of cer	ljer V	Cas	tu	J. M.t	29c. Licens	24389	146	Oct 7	te signed (Mor	1th, Day, Year) 4, 200k)
10			30. Name and address of pers	-0	completed cau	se of de	ath (Item 23a) (Typ	e, Print) Union	Memo	mal	Hosp	ital	MD	
Reç	Sta gistra	ie ar	31. Date filed (Month, Day, Ye OCT 0	5 2	006	egistra/	s Signatura	fords				/		

xaminer inding physicien and use as the burial-transit this After within 24 hours after death.

To the Funerel Diractor: A completely filled in by the fu

Physician

/Medical

Examiner

Funeral

Director

il Hygiene. other than "natural", or items 23s or 28s-1 show vent, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours atterment of Health and Mental Hygiene.
ent: if Item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Evantina

permit. Page Department of Importent: if any injury or ance.

Physician

Examiner

Baltimore, Maryland 21215-0036

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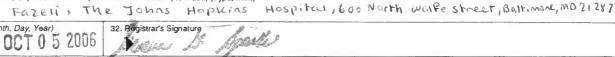
12+1 State

Physician/Medical signed by the e ۵ Completed s certificate has t lirector, page 2 s director Be funeral Certification: 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Fazeli, MO Parastoo OP19513 october 1, Zoa 6

31. Date filed (Month, Day, Year) 2006 OCT 05

Parastoo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

		1 - For State Registrar	State	of Marylan	id / Depa <i>Cei</i>	artment of F tificate of	lealth and <i>Death</i>	Mental Hyg	gienez Reg. No.	006	31557
Physici	an	Decedent's Name (First, Middle,	Last)	-		Dunst	-0.4	2. Date of Dea	Day	Year	3. Time of Death
/Media	cal	4a. Facility Name (If not institution,	aire street and no	(mhar)			r Location of Dea	October 11th	4c, Co	2006 unty of Death	11.70 %
Examir	er	- 1 ·	pkins 1	day n.t.	١	Raltin		Cita			N/A
Funeral Director			6. Sex 1 □ M 2 □ X F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Da	h , Year) 2, 1955	9. Birth	place (State or Foreign ntry) Maryland
P.		Usual Residence of Decedent		100 0	ty, Town or La	antin					10d. Inside City Limits
arylar show	_	10a. State 10b. County	N/A	100. 011	ty, rown or Lo		Baltimore 1 □Ye				
he M	Director	Maryland 10e. Street and Number	14/74			10f. Zip Code			10a. Citizer	of What Cou	ntry?
with	ក	534 Random Road				101. Zip 0000	21229			U.S	*
heath re 23	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13.	Was Decedent of H	lispanic Origin? (14.	Race - Ameri		
72 hours after o "natural", or iter adical Examiner		1 ☐ Mever Married 2 ☐ Marri		2 🗆 N O		If Yes, specify Cub	an, Mexican, Pue	erto Rican, etc.)		Black, White,	
ral', o	l by	3 Widowed 4 Divorced	If Yes, G Year or I	Dates:		TLI Yes ZLINO	Specify:		Sp	ecify:	Black
be filed within 72 hours after death with the Maryland tal Hygjene. d other than "natural", or iteme 23s or 28s-f show event, the Madical Examiner must be incitived at	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working (ife. DO NOT use retired)							16b. Kind	of Business/Ir	ndustry
d 2 should be filed within the and Mental Hygiene. Z7 is marked other than 'traumatic event, the Ma	шď	Elementary/Secondary (0·12) College (1-4or 5+) life. DO NOT use retired) Nursing							Provident Hospital		
be filed v ital Hygie id other t		12 17. Father's Name (First, Middle, I	ast)		1		18. Mother's Na	ame (First, Middle,	Maiden Su	mame)	
	Be C		nnie Dunsto	n				Wilh	elmina [Dunston	
s 1 end 2 should be f Health and Menta item 27 is marked other traumatic ev	မ	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address (Street	and Number or F	Rural Route Numbe	r, City or T	own, State, Zi	p Code)
47.50 to 12.50 to 12.		Wilhelmina Dunstor	Mother		;	3600 West F	ranklin Stree	et - Apt 5e Ba	ltimore,	Maryland	21229
item 2		20a. Method of Disposition	a 🗆 🗆	1 .	Place of Dispo	sition (Name of matory or other pla	ce)	Date		ion - City or T	
Pages nent of I unt: If It		1 ☐ Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State	Arbi	utus Memoria	al Park	10/09/06		Baltimore,	, Maryland
permit. Pages 1 en Department of Heal Important: if item 2 any injury or other once.	1	21. Signature of Funeral Service I	icenee	Dacke	2:	2. Name and Address Estep	Brothers Fu	ineral Service Baltimore, N	, P. A. Id 2121	7	
		23a. Part1. Enter the disease, or shock, or figart failure. List	complications that	caused the dear	th. not en			ac or respiratory a			Approximate Interval Between
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/Medical		resulting in death)	aDue to	(or as a	(uence of):		_				2
Examiner	н	Communication for conditions	, £	and St	uze	Liver	failure				12 Days
₽ 7// Ħ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is littled expense.	quence of):	irrhaus					11		
and frans	Examiner	that initiated events resulting in death) Last					7 years				
ficate be executed g physicien and	al E			o (or as a consec	dollos ol).						•
physic steel	dical		d.								
Physicien: The law requires that the death certificate be executed this certificete has been signed by the attending physicien and radiarctor, page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn					230	I. Date of deliv	very
death atter	clar	in the past 12 months?	4□Preg	birth 2 ☐ Feta gnant at time of a		⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _	y			Month	Day Year
that the de ned by the a detached t	hys	9 Unknown	9□ Unk	nown							
uires that signed b d be det	y P	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	inderlying cause gi	ven in Part I.	23e. Did t		,	the cause of death?
w require been sig should b								- 10	Yes 2	No 3□Pro	bably 4 Unknown
ie law requ has been ge 2 shouk	Completed							24a. Was	osv	24b. Were aut	topsy findings available omptetion of cause of
The ete his	ĕ							perfo 1 ☐ Yes	2XI No	death? 1 ☐ Yes	2 No
ertifica ctor,	Be	25. Was case referred to medical examiner?						eath (Check only	one)		
hysic his ce Il dire	10	1 ☐ Yes 2 No			ER/Outpatie	nt 3 DOA		Home 5 ☐ Resi			alfy)
Ing P		27. Manner of Death		e of Injury onth, Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury o	occurred	
Attending or death.	cat	2 Accident investig	not be	an of Indiana At h]Yes 2 □No	28f Location /	Street and I	Number or Ru	ral Route Number,
i or At after o Direction by	Certification:	4 ☐ Homicide determ	100d 200, Fide	ding, etc. (Spec	ify)	reet, factory, office		City or To			
To the Hospitel or Attending Physiclen: The I within 24 hours after death. To the Funerel Director: After this certificete ha completely filled in by the funeral director, page	edical Ce	29a. Certifier Certifyin (Check only 2 Medical	g Physician: To the Examiner: On the	he best of my kn	owledge, dea	th occurred at the to	ime, date and pla opinion, death oc	ace, and due to the courred at the time,	cause(s) ar	nd manner as ace, and due	stated. to the cause(s)
the F the F the F	Medi	one)	and ma	inner stated.			se number			signed (Month	
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./						1 Kes	> - 0 00			W -	2008
5		30. Name and address of person	who completed ca			HAL GOD	No-th V	Volfe Street	et, Bul	hmore /	2006 Maryland 2128
	ate	MOSI Bennett 1		Registrar's Sign	-	·	· Jin				-
Si Regis	ate	OCT (5 2006	A Maria Const	e de	AND ALL					

State of Maryland / Department of Health and Mental Hygiene,

Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Paul Anthony DeBoeser, Jr. October 0 2006 9:00 A. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 145 W. Meadow Road Baltimore Anne Arundel Il Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 ☐ F 218 42 3415 61 Yrs. Director Dec. 2. Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at Maryland Anne Arundel Baltimore 1 Yes 27 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 145 W. Meadow Road 21225 U.S. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or itams 11. Marital Status 1 ⊠Yes 2 No
If Yes, Give
Year or Dates: Viet Nam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ring most of working al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th Contractor Construction permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: if Itsm 27 is markad oth any liury or other traumatic svent 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Doris E. McAfee Paul A. DeBoeser, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary DeBoeser / wife 145 W. Meadow Road Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 10/5/2006 4 Donation 5 Other (Specify) 21. Signature of Funeral, Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certilicate be executed Division of Vital Records, P.O. Box 68760,亿 that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MEZCITO 3 Probably 4 □Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of performed 1 Yes 2 No 1 Yes 2 No Alter this certification funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No neral Diractor: A within 24 hours efter death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Pey, Year) address of person who completed cause of death (Item 23a) (Type, Print) HANOVER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 0 5 2006 DHMH 17 Rev 1/2001

			1- For State of Maryland		ent of Health and ate of Death	Mental Hygien	
			Negistrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
П	Physicia		Oram Roland Eck			SEPENBER S	26 306 5.02 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. Ci	ity, Town, or Location of Deat		c. County of Death
			LORIEN (a) KIURSIDE		BeloaMD		ARREPORD
	Funeral	-000	5. Social Securify Number 218-14-8130	st birthday) If Uni Month	der 1 Year If Under 24 Hrs hs Days Hours Min.	(Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	113.		May 6, 19	24 Maryland
	/land			Town or Location			10d. Inside City Limits
	Many B-f ah	ğ	Maryland Harford Co.	Abingo	don		1 □ Yes 2 No
	or 28	Jre(10e. Street and Number		Zip Code		Citizen of What Country?
	ours elter death with the Marylan elf, or items 23e or 28e-f show Examiner must be notified at	Funeral Director		. 204	21009		nited States
	items items	nue	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married	13. Was De	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puer	to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	of', or	by F	3 Widowed 4 Divorced Year or Dates:	1 🗆 Yes	s 2 No Specify:		Specify: White
21215-0036	tiled within 72 hours etter death with the Maryland Hygiene. ther than "naturel", or items 23a or 28a-f ahow int, the Medical Examinat must be notified at	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's U	Isual Occupation work done during most of wo	dking 16b.	Kind of Business/Industry
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	tiled w Hygier other th		12 yrs. 17. Father's Name (First, Middle, Last)	POST	al Carrier	me (First, Middle, Maide	.S Postal Service
Maryland	ntal H	Be	Melvin Washington Eck, Sr.		Ada		
<u> </u>	2 should be and Mental is marked of sumatic eve	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addr	ress (Street and Number or R		
	nd 2 aith a 27 is		Mrs. Shirley T. Eck / Wife	20 Box H	ill S. Parkway	Apt. 204	Abinadon, MD 21009
Je,	es 1 a of Hea fitem r othe	'	20a. Method of Disposition 20b. Pla	ce of Disposition (inetery, crematory)			Location - City or Town, State
Ē	Pages nent of sent: If it ury or o		1 Libural 2 Ucremation 3 Linemoval from State	kwood Cer	'00/	30/2006 P	arkville, Maryland
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 ho Deperment of Health and Mental Hygiene. Important: if item 27 is marked other than "natureny injury or other treumstic event, the Medical BDGs.		21. Signature of Funeral Service Licensee		e and Address of Facility onard J. Ruck		5 Harford Road timore, MD 21214
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heer failure. List only one cause on each line.				Approximate Interval Between
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Δ.	that the	Ph	Part II. Other significant conditions contributing to death but not result	ting in the µnderlyir	ng cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
Records,	uires I sign	d by	Atrial Fibral	lation		1 ☐ Yes	2 No 3 Probably 4 Unknown
O	w requir been si should I	iete		10101	DICOCO	24a. Was an	24b. Were autopsy findings available
Re	The law	Completed	COVONAVY AV	Tory	Discus	autopsy performed 1 ☐ Yes 2	prior to completion of cause of death? No 1 \(\text{Yes} \) 2 \(\text{No} \) No
Vital		BeC	25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)	
<u>></u>	Physician: r this certitics ral director, p	ို	1 Yes 2 No Hospital 1 Inpatient 2 E			Home 5 Residence	
Division of	ath. r: After t	iio iii	1 Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in	ijury occurred
isio	ttendi death. ctor: A ctor: A	cat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hon			28f. Location (Street	and Number or Rural Route Number,
Di∨	after after Direct	ertif	4 Homicide determined building, etc. (Specify)	To, raini, stroot, rac	J. J	City or Town, St	
	To the Hospital or Attanding I within 24 hours after death. To tha Funerel Director: Atter completely tilled in by the funer	Medical Certification:	29a. Certifier (Check only one) Certifying Physician: To the best of my know and manner stated.				
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	1	29c. License number	29d.	Date signed (Month, Day, Year)
	/		11 01 amil 111-la	W.	N1828	5	10/3/06
	5	п	30. Name and address of person who completed cause of death (frem	(Type, Print)	3 kan	STREET,	1 Aberleen
	CI	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	Jre F	Mo	ryand	400
	Regist		OCT 0 5 2006	South		1	
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			1- State of Maryland / Department of Health and M Certificate of Death	ental Hygie Reg.		31560						
	Dhario		Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death						
	Physicia /Medic		MARY VIRGINIA EDELMAN	OCTOBER	4, 2006	11:54 A.						
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PRESBYTERTAN HOME OF MARYLAND TOWSON		4c. County of Deal							
2	-		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	BALTIM 9. Bin	hplace (State or Foreign						
Ž	Funeral Director		219-10-9675 1 M 2 XF 82 Yrs. Months Days Hours Min. Usual Residence of Decedent	(Month, Day, Ye 12/25/19	23 MA	RYLAND						
Paci.	MO M		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
Man	Fied h	to	MD BALTIMORE TIMONIUM			1 ☐ Yes 2 X No						
distribution of	Should be led which 2 hours arise used; with the waysand Mandale Hygiens a marked other then "naturel", or items 23a or 28a-f show umatic event, the Modical Examiner must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code 2123 FOLKSTONE ROAD 21093	10g.	Citizen of What Co	ountry?						
1000	ms 2	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe Armed Forces? 14. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerlo	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit							
020	ei', or it	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No Specify: Year or Dates:	, , , ,	Specify: WHI							
	natur	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) (life DO NOT use retired)	ng 16t	o. Kind of Business	/Industry						
7	hen.	mpl	Elementary/Secondary (0-12) College (1-40r 5+)		PUBLISHI	VG						
7	Hygie ther t		12IR GRADE	(First, Middle, Mai	den Sumame)							
מומ	should be lifed withing the Manual Hygiene. marked other then amatic event, the Manual	To Be		RGINIA SH	ANNON							
Mary	is 1 and 2 should be lied within 12 hours after deaut with the way yat Health and Mental Hygiene. It was a straight of them 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) LINDA SEWARD/DAUGHTER 19b. Mailing Address (Street and Number or Rural 2123 FOLKSTONE RD. TI	N Route Number, C	•	Zip Code)						
more,	permin. Pages i end z Department of Heath a Important: If item 27 is eny injury or other tra once.		20a. Method of Disposition 1XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) MORELAND MEM. PARK 10/9/4		LLENDALE,							
Daltimor	Departm Departm Imports eny inju	22 Name and Address of Society (NUID TOURISM) THERE AT LIGHTED AT										
e 3	FILE		23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.		•	Approximate Interval Between						
	hysician /Medical		Immediate Cause (Final disease or condition a Acade my occardiol interest			30 m. hates						
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	od ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
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O. Box	ie law requires trat the death certificate be executed has been signed by the attending physicien and ge 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown		23d. Date of de Month	livery Day Year						
ds, r	signed by d be deta	þ	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.		9.4	o the cause of death?						
ည္း	aw 1st 2s	Completed		24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of						
	inficate or, pa	ပိ	25, Was case referred to medical 26. Place of Deat	1 Yes 2 h (Check only one)	No 1 ☐ Yes	21⊠ No						
	rnysicien: rthis certific ral director,	To B	examiner? , Userial:	me 5 Residenc	e 6 □Other (Spe	icify)						
ם הם	aing Ph		1 Matural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how	injury occurred							
DIVISION	To the hospits of Atlanding Prystoten: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S		ural Route Number,						
-	4 hours a	edicai Ce	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.									
	thin 2 the mplet	Med	one) and manner stated. 29b. Signature and tiple of certifier 29c. License number	29d	. Date signed (Moni	th. Day. Year)						
1	\$ 1 8 5		Attending my D37016	230	October 5	1,2006						
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth m. Greene, ~ 2 6701 N. Charles St., Sa te 4105	S. 42.	on, my	21204						
	Sta Regist		31. Date filed (Month, Day, Year) OCT 0 5 2006		•							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (1) 6 Figure Amend #5 Per FH G860 10/05/06 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2006 92,90 marion 8 OCTOBER 1.15PM 4a. Facility Name (If not institution, give street and nut 4b. City, Town, or Location of Death andally MONTHWEFE Roth If Under 24 Hrs. 5.212-34-v696- Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Month, Day, Yea 06/16/192 1 M 2 XF Months Hours 212334-6967 VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County **Baltimore** n/a 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 Campfield Road 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: Black Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) n/a Elementary/Secondary (0-12) 9th housekeeping Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Robb Sally Ann Roy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Inez Robb / Daughter 918 N. Fulton Avenue; Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/06/2006 Druid Ridge Cemetery Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service License 638 N. Gilmor Street; Baltimore, Maryland 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NEUMONIA

Physician /Medical Examiner

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rai', or items 23e or 28e-f ehow Examiner must be notified at

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Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiane. Int: If item 27 is marked other than "natural", or item

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit signed by tha e this death. the within 24 hours after deat To the Funeral Director: filled in by

Division of Vital Records, P.O. Box 68760,

	Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b			
that initiated events resulting in death) Last	Due to (or as a consequence of): d.			
Sequential is continued as a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 MNo 9 Unknown Part II. Other significant conditions continued to the continued of		opic pregnancy her (specify)	2	23d. Date of delivery Month Day Year
Part II. Other significant conditions con Chronic obstruch	intributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death? ☐ No 3 ☐ Probably 4 XUnknown
Congestive h	eart forwer.		24a. Was an autopsy performeg? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25 Was case referred to medical		26. Place of Death	(Check only one)	
examiner?	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3	Other: 4 Nursing Hor	ne 5 Residence €	G ☐ Other (Specify)
1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only onle) 29b. Signature and title of certifier 1		28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury	y occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier (Check only one) (Check only one) (Check only one)	iner: On the basis of examination and/or invest and manner stated.	curred at the time date and plane is igation, in my opinion, death occurre	and due to the cause(s) and at the time, date and	and memour as stated place, and due to the cause(s)
29b. Signature and title of certifier	MHYSICIAN	29c. License number	29d. Date	e signed (Month, Day, Year)

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29d. Date signed (Month, Day, Weal)

State Registrar

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31. Date filed (Month, Day, Year)
OCT 0 5 2006

To the Hospital

e of death (Item 23a) (Type, Print)

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32 Registrar's Signature

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State of Maryland / Department of Health and Mental Hygien 006	3	51	5 2
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		•	for State Registrar	State of Ivia		ertificate of		Reg.		01002
			Decedent's Name (First, Middle, Last	st)		· · · · · · · · · · · · · · · · · · ·		2. Date of Death		3. Time of Death
	Physicia /Medic		Melva Audrey Spo	nsler Faut	h			October	3, 2006	9:50 A. M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of Deatl	n
			Ridgeway Manor				sville		Baltim	
	Funeral Director		215-0/-614/	ex 7. Age ☐ M 2 ☐ F 89	(In yrs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Oct. 9, 1	9. Birth 916 Mary	nplece (State or Foreign untry) 'Land
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
,	Mary	ō	Maryland Baltimo	re	Cator	nsville				1 ☐ Yes 2X No
	28a	rec	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
3	38 o 18	Funeral Director	5903 Foxhall Man	or Drive		212	28		USA	
	deat	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	3. Was Decedent of H	Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame Black, White	
000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In important it flem 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination and the notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 📆 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 🛣 No			Specify: White	
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V :	iled v		12 17. Father's Name (First, Middle, Last)		Home	emaker	18 Mother's Nam	e (First, Middle, Ma	Own Home	
yland	d be f	Be	John Boswell Spo					Eugenia C	,	
<u> </u>	mark mati	ဥ	19a. Informant's Name/Relationship (19b. Ma	uiling Address (Street	1			(ip Code)
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บั	f Healifern item othe		20a. Method of Disposition	-	20b. Place of Dis	position (Name of rematory or other pla	ce)	Date 20	c. Location - City or	Town, State
	Page Tent of Int: If	١.,	© Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Druid Ri	ldge Cemet	ery 10-7	-2006 Pi	kesville,	MD
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ב ב	: The law cate has t page 2 s	mo						autopsy performe	d? death?	completion of cause of
		C	25. Was case referred to medical				26. Place of Deal	1 ☐ Yes 2 ☐	MANO IL TOS	2 NO
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	To the To the comp	Ň	29b. Signature and title of certifier	Para.	May	29c. Licen	se number	()	Date signed (Monti	n, Day, Year) H, 2006 21228
2	5		30. Name and address of person who	completed cause of de	eath (Item 23a) (Tvr	pe, Print)	/3 - / /			1 2 2 3
1			B. TURAKI	TIA MO	1009	Freder	ch Rd.	Ceturin	The my	21228
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			For State Registrar	State of	Maryland /		rtment of H tificate of L			giene Reg. No. 20	06 31563
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	/Medic Examir		4a. Facility Name (If not institut		ber) Hmekc		4b. City, Town, or Balh			4c. County	
ı	Funeral Director		5. Social Security Number 213-26-6405	6. Sex 1 ☐ M 2 ☐ X F	7. Age (In yrs. last I 76	ointhday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		^h , 1930	9. Birthplace (State or Foreign County) Maryland
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lation baltimore.	ges 1 and 2 it of Health if item 27 or other tra		Andre Monroe D 20a. Method of Disposition 1 Surial 2 Crematio	n 3 Removal from S	00000	of Dispos tery, crem	ition (Name of atory or other place	9)	Date 10/05/06	20c. Location -	City or Town, State
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8760.	and tran	dical Examiner	that initiated events resulting in death) Last	c. Due to (c	or as a consequenc	e of):					
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P.O. B	t the deetl by the atte ached for	hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at time of death		Ectopic pregnancy Other (specify)			Mor	nth Day Year
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Divi	To the Hospital or Attendi within 24 hours after death To the Euneral Director: A completely filled in by the fa	Certification;	4 Homicide dete	mined 289. Place buildin	of Injury - At home, ig, etc. (Specify)				City or Tou	vn, State)	er or Rural Route Number,
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State of Maryland / Department of Health and Mental Hygiene 005 31564 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 4, Katherine Gale October 2006 7:57 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Middle River
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | (Month, Day, Year) 39 Left Wing Drive Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) tf Under 1 Year Months Days Birthplace (State or Foreign Country) **Funeral** 1 □ M 200 Director 219-38-7834 98 05/19/1908 New Hampshire Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-fehow th and Mental Hygiene. 27 is marked other than "natural", or itema 23a or 28a-1 ehov treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be flied within 72 hours elter death with t Department of Heelth and Mental Hygiene.
Importent: if item 27 is marked other than "natural; or items 23a or 2 ary injury or other treumatic event, the Medical Exempters. 39 Left Wing Drive S. A. 14. Race - American Indian, Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Slatus Black, White, etc. 1 ☐ Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: XXWidowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Etementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Thomas Guessford Jackson Eva Amazeen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Gale (Son) 39 Left Wing Drive Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 10/07/2006 1 → Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens Bel Air, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Signature of Euperal Service Licentiss 1407 Old Eastern Avenue Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part1. Extact the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. tramediate Cause (Final disease or condition resulting in death) (LISNAL **Physician** /Medical Due to (or as a consequence of) Examiner MEMIA Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner ACCINENT MEBRO V ASCUMAN The law requires that the death certificate be executed 4 MOS burial-tran MSEASE Box 68760. Physician/Medical tor use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. page 2 should be detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records. CANCER 1 Yes 2 No 3 Probably 4 Unknown Be Completed MELANOMA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No Division of Vital Hospital or Attending Physician: Atter this cartific tuneral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 3□ DOA Sid 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 Yes 2 No I hours after death. uneral Director: A sly tilled in by the tu death. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier D-48025 am b 30 Name and address of person who complete cuse of death (them 23a) (Type, Print) CHEDAGO AVE, BALTO, MT 21237 SUD ARNI 32. Fingistrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

			For State Registrar	State of Marylan	-	artment of H			giene neg. No 2006	31565
	Dharaiai		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death
	Physicia /Medic		Charles Louis Gri	Lm				October	3, 2006	11:00 P ^M
	Examin		4a. Facility Name (If not institution, give s	•		4b. City, Town, o		th	4c. County of Deat	
			Ridgeway Manor Nur		4 6 1-46 -61	Catons If Under 1 Year			Baltin	
	Funeral Director	Ì	5. Social Security Number 6. Sex 199-01-9769	7. Age (In yrs. I	Yrs.	Months Days	Hours Min	. (Month, Day		hplace (State or Foreign untry)
			Usual Residence of Decedent	90				Feb. 20	, 1910 Mary	Tanu
	ylanc		10a. State 10b. County	10c. City	r, Town or Lo	cation				10d. Inside City Limits
	Ba-f-e	cto	Maryland		Ba1	timore				1⊠Yes 2□No
	deeth with the Maryland me 23a or 28a-f ehow rmust be notified at	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
	23a	ara .	502 Woodside Road	2. Was Decedent Ever in U.	0 40.1		.229	04	USA 14. Race - Ame	riana ladina
	item item	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 □ No	5. 13. 1	was Decedent of H	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Black, White	
50	hours after tural', or ite al Examina	þ	3 ∰Widowed 4 □ Divorced	tf Yes, Give Year or Dates: 1941-	-45	1 ☐ Yes 2 🙀 No	Specify:		Specify: W	hite
9500-512	be filed within 72 hours after dee tal Hygiene. Id other than "natural", or Iteme event, the Medical Examinar m	Completed	15. Decedent's Educ	ation	16a. Deced	dent's Usuaf Occup	ation	artina	16b. Kind of Business/	Industry
Z	within 72 ene. then "nel	npie	Efementary/Secondary (0-12)	Coffege (1-4or 5+)	life.	DO NOT use retired	d)	Jinnig .		
_	filed w Hygier Sther th	S		4+	Elect	rical Eng			BG&E	
Maryland 2		Be	17. Father's Name (First, Middle, Last) George J. Grim					me (First, Middle, Mattfeld		
Ž	should be nd Mental nmarked o	၉	19a. Informant's Name/Relationship (Type	ne Print)	19h Marlin	on Address (Street			r, City or Town, State, 2	in Code)
	end 2 sho ealth and n 27 ie m		Richard D. Grim		1				e, Maryland	
ē,	一工事专		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place	ral	Date	20c. Location - City or	Town, State
Ê	00		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			ematory	10/5	5/2006	Catonsville	e, Maryland
Baltimore,	permit. Peg Depurtment Important: I any injury o		21. Signature of Funeral Service License	10 11	22	2. Name and Addre	ss of FacilitySt	erling As	hton Schwal	b Witzke
<u>n</u>	898		Mag	Cell	11	<u>630 Edmor</u>	ndson Av	enue; Cat	onsville,	MD 21228
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the deatle cause on each fine.	n. Do not ent	er the mode of dyir	ng, such as cardia	ac or respiratory an	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pecurly Due to (or as a conseq	Karry	vatur po	reunn	w.		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	1.	r acela	1. v		-
H		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	uence of):	whatula	racua	lur		1 year
	d Insit	Examiner	Cause (Disease or injury							
<u></u>	exection and and rial-tra		that initiated events cresulting in death) Last	Due to (or as a conseq	uence of):					
8/60	cate be executed physicien and tha burial-transit	dical								· · · · · · · · · · · · · · · · · · ·
Ó	ing ph	Med	IF FEMALE:							
POX	death certific e attending pl ed for use as t	lan/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1☐Live birth 2☐Feta	Ideath 3	Ectopic pregnancy	,		23d. Date of del	ivery Day Year
0	0 00	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of d	eath 5	Other (specify)				-Ly
a.	The law requires that the de the has been signed by the bage 2 should be deteched		Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause on	ren in Part I.	23e. Did to	obacco use contribute to	the cause of death?
gs	uires sign id be	d by	Hypertens	w. Ou	rlices	mellili	in	1 🗆 Y	'es 2€No 3□Pr	obably 4 Unknown
S	s beer	Completed		/				24a. Was	an 24b. Were au	itopsy findings available
ž	The lay te has age 2	mo							rmed? death?	completion of cause of
<u>ta</u>		Bec	25. Was case referred to medical	-			26. Place of De	eath (Check only o		20140
<u>></u>	Physic this ce al direc	ToE	examiner? 1 □ Yes 2 ◯ No		ER/Outpatier	nt 3□ DOA Ott	er: 4 9 Nursing	Home 5□Resid	lence 6 Other (Spec	ci ly)
0	ding Ph h. After th funeral		27. Manner of Death 1	28a. Date of fnjury (Month, Day Year)	28b. Time o fnjury	Wo		28d. Describe h	now injury occurred	
Sio	tendi Jeath tor: A	cati	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ No	006 1 10 10		
Division of Vital Records,	or Attendent after deatl Director:	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the control of	ome, farm, sti v)	eet, factory, office		City or Tow	Street and Number or Ri vn. State)	irai Houte Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director;		29a. Certifier 1 Certifying Phys	sician: To the best of my kno	wledge, deat	h occurred at the ti	me, date and place	e, and due to the	cause(s) and manner as	stated.
	ne Ho	edicai	(Check only 2 Medical Examile one)	ner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	pinion, death occ	curred at the time,	date and place, and due	to the cause(s)
	To ti withii To ti comp	¥.	29b. Signature and title of certifier	0. 1		29c. Licens			29d. Date signed (Monti	
			1 amail	Burchers	10		14114	(Deletile 4,0	0006
1	3+1		30. Name and address of person who co	mpleted cause of death (tten	23a) (Type,	Print) PA~	ZAN R.	BERCHE	56 441	
1	d		5 411 OLD PREE	DERECK RD &	E18 1 B	ACTION	E MAC	SATURNO"	21229	
	Sta Registi		31. Date filed (Month Car Year) 5 20	DERECK RD A	Is to	parke				

	1	For State Registrar	State of Marylar			nt of H		Mental H	ygiene Reg. No. ¹	2006	31560									
Physicia /Medica	1	1. Decedent's Name (First, Middle, Las MIChael	T. Golabo	ski				2. Date of Month	29 29	700 (3. Time of Death 1935 M									
Examine Funeral Director		Baltimore Washing 5. Social Security Number 218-01-4242	ton Medical C		G1e	n Bur Days	Location of Dea Cnie If Under 24 Hr Hours Mir	S. 8. Date of (Month,	An	ne Arun	de1 place (State or Foreign									
yland		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo				1 00/2	7/1710		10d. Inside City Limits 1 ☐ Yes 2 ☐ No									
or 28e	Direc	10e. Street and Number	N N N N N N N N N N N N N N N N N N N							en of What Cou	ntry?									
Urs after	by Fur	105 Baylor Road 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates:	3			spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or into Rican, etc.)		.A. 4. Race - Ameri Black, White, Specify: Whi	etc.									
	To Be Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	(ucation de completed) College (1-4or 5+)		dent's Usi kind of w DO NOT	ork done d use retired,	tion uring most of w	orking		d of Business/In	•									
Maryland d 2 should be file th and Mental Hyg i7 is marked othe traumatic event,		17. Father's Name (First, Middle, Last) George Golabosk	i				18. Mother's Na Helena	ame (First, Midd Madra	dle, Maiden S	Sumame)										
Nore, Maryland 212 ges 1 and 2 should be filed withi t of Health and Mental Hygiene, if it is marked other than or other traumatic event, the M	-	19a. Informant's Name/Relationship (Mr. Craig S. Gola 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	boski / son		McKi	nsey	Road; S		Park,	MD 211	46									
Baltimore, permit. Peges 1 an Depertment of Heal important: if Nem 2 eny injury or other		4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	St		2. Name a	nd Addres	s of Facility		n Fun	timore, eral Ho MD 2106	me, PA									
PB/00, Wedical physicien and physicien and physicien and stree printing it is the printi	Completed by Physician/Medical Examiner	Completed by Physician/Medical Examiner	Completed by Physician/Medical Examiner	Completed by Physician/Medical Examiner	Completed by Physician/Medical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consect to Due to Due to (or as a consect to Due to Due to (or as a consect to Due to	quence or):	odon	<u> </u>	Aur	hì /	mey	rysm	Inierval Between Onset and Death					
						Completed by Physician/Mi	Completed by Physician/Mi	Completed by Physician/Mi	Completed by Physician/M	Completed by Frigsicialium	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	aldeath 3	Ectopic p	oregnancy pecify)			2:	3d. Date of delive Month	ery Day Year
w requires that been signed be should be deta											completed by	בר ב	בר ב	בר ב	Part II. Other significant conditions o	n in Part I.		23e. Did tobacco use contribute to the cause of death		
Of VI(al Hecords, Physician: The law requires t ribis certificate has been signe rial director, page 2 should be																		24a. W au pe 1∐ Yes	topsy rformed?	24b. Were auto prior to co death? 1 ☐ Yes
OT VIII Physicia this certi al directo	ם ו	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 🕽	R/Outpatier	nt 3□ D	OA Othe	•	eath <i>Check onl</i> Home 5 Re		Other (Special	(v)									
To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	1 Matural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No								28d. Describe how injury occurred											
To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)																			
Hosi 124 ho ie Fune letely fi	Medical -	29a. Certifier 1 Certifying Ph (Check only 2 Miculical Examone)	ysician: To the best of my known of the pasts of examination and manner stated.	owiedge, deat ation and/or in	n occurred vestigation	at the tim	e, date and place inion, death occ	ce, and due to the curred at the time	ne cause(s) a e, date and p	and manner as s place, and due to	stated. the cause(s)									
To the withing To the comp	M	29b. Signature and title of certifier	- As	N		DY1			29d. Date	signed (Month,	Day, Year)									
10		30. Name and address of person who are the company of the company	completed cause of death (Item	14 3	Print)	0601	TAL D	n Gi	£4 (BURNIE	MD 210									
State Registra		OCT 0.5.20	06 A Page A	B A	sels)	7														

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** September 820M arolyn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balti more (timore Hospital 04 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. DEC . 15, 1951 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ F 54 MARYLAND 219 56 2975 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State f Health and Mental Hygiene. Item 27 ie marked other then "natural", or Items 23a or 28a-f ehow other treumatic event, it a Madical Examinat must be notified at 1 Tyes 2 No Director BALTIMORE MIDDLE RIVER MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14 VIMY COURT 21220 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OFFICE POSTAL CLERK 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LINDSAY KELLY HESTER JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Health a Importent: If Item 27 is any injury or other tree once. NATIARA GRAY (daughter) 14 VIMY CT. MIDDLE RIVER, MD. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) OCT. Date 5 , 20 0 0 C. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATL.MEMLPK. LAUREL, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ganzlia (2) hematoma acute badal delys **Physician** /Medical Due to (or as a consequence of): Examiner TN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of) Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Dav 5 Other (specify) 4☐Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed rector, page 2 should be de ģ 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes 1 ☐ Yes After this certific funeral director, 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 1 Yes 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 Homicide within 24 hours after To the Funeral Dire

Box 68760, P.O. 1 Division of Vital Records,

Saltimore, Maryland 21215-0036

Parolyn

State

completely

Medical

29a. Certifier

(Check only one)

29b. Signature and the of certifier

Registrar

DHMH 17 Rev 1/2001

Wiesenberger 31. Date filed (Month, Day, Year)
OCT 0 5 2006

M.D

29c. License number

Sina,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State	State of Marylar	•		Mental Hygie	0000	. 01500	
			Registrar		Certifica	te of Death		. No. 2 U U 6	9100	
н	Physici	an	Decedent's Name (First, Middle, Last	it)			2. Date of Death Month	Day Year	3. Time of Death	
	/Media		William H	Goody Sr			10	2 200	VL	
1	Examin	er	4a. Fecility Name (If not institution, give		4b. City	, Town, or Location of Dea	th	4c. County of Deat	ın	
_			Johns Hapkins Bay 5. Social Security Number 6. S		last hirthday) If Under	er 1 Year If Under 24 Hr	s. 8 Date of Birth	9 Birt	thplace (State or Foreign	
	Funeral Director			MM 2 F	6 Yrs. Months			earlatto in	ARVLAND	
			Usuel Residence of Decedent	4			June 40		ANYCANO	
	ylan		10a. State 10b. County	A	ty, Town or Location				10d. Inside City Limits	
	e Ma	cto	MARYLAND V	4. B.	ALTIMORE	2			1 Yes 2 No	
	ith th	Director	10e. Street and Number	11/2 1 1 2 1 1 1 2	10f. Z	ip Code	10g.	. Citizen of What Co	ountry?	
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	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13. Was Dec	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	Specity Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit		
36	rs eft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☑ Yes 2 □ No [9 (If Yes, Give Year or Dates: 9 (1 Yes	2 No Specify:		Specify: W	hite	
21215-0036	within 72 hours efter ene. than "natural", or Ita he Medical Examina	ed	15. Decedent's Ed	lucation	16a. Decedent's Us	ual Occupation	16	b. Kind of Business/	/Industry	
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2	od wit	mo:	12	NA	Chief St	REROUM AT	Tendant			
	at Hygie I othar vant, II	Be	17. Father's Name (First, Middle, Last)		1	18. Mother's Na	ame (First, Middle, Mai	iden Sumame)	14	
yla	should be nd Mental markad	၉	MAXON	6	oudy	EldA	1	MARSH	All	
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	l and lealth im 27		20a. Method of Disposition	A No. of the last	Place of Disposition (N	The state of the s	15/A 11 j P	c. Location - City or	The State	
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ital		0	25. Was case referred to medical			26. Place of De	eath (Check only one)	10 10	- 2010	
f <	Physician: rathis certition	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 0	OA Other: 4 Nursing	Home 5 ☐ Residence	e 6 □Other (Spe	city)	
0 _	ng Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred		
sio	Attending ir death.	catl	2 Accident investigation 3 Suicide 6 Could not b	,	М	1 ☐ Yes 2 ☐ No				
Division of Vital Records,	atter death atter death Diractor: /	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, facto fy)	ry, office	28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,	
	pital ours a eral [29a. Certifier 1 Cartifying Ph	ysician: To the best of my kn	owledge death	d at the time, data and of-	and due to the accord	ea(e) and masses	estated	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical		niner: On the basis of examinand manner stated.	ation and/or investigation	n, in my opinion, death occ	curred at the time, date	and place, and due	to the cause(s)	
	To thi within Fo thi compli	Me	29b. Signature and title of certifier	0.	2	9c. License number	29d.	. Date signed (Mont	n. Day, Year)	
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	· nxl		30. Name and address of person who	completed cause of death (Ite				001 00		
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D1		1. Decedent's Name (First, Middle, Last)			11	2	. Date of Death	h Day Yea	3. Time of Death
Physic /Medi		WILLIAM			HARRIS		1 1	MUEB 2426	I Portion M
Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or Location	n of Death		4c. County of De	eath
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Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	Yrs.	Months Days Hours	Min.	. Date of Birth (Month, Day, 06 07	Year)	Birthplace (State or Foreign Country) MD
		Usual Residence of Decedent	33				00 07	33	MD
yłanc how		10a. State 10b. County	10c. City	, Town or La	cation				10d. Inside City Limits
e Ma	cto	MD NA	Ba	ltimo	re				1 XYes 2 No
or 28	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What	Country?
ath w s 23a	rai	217 Beale Court			2123			U.S	
tiled within 72 hours after death with the Maryland Hygiene. Whysiene. Wher than "naturel", or Items 23a or 28e-1 show ont, the Medical Examiliant country.	Funerai	111111111111111111111111111111111111111	12. Was Decedent Ever in U.S Armed Forces?	5. 13.	Vas Decedent of Hispanic C f Yes, specify Cuban, Mexic	Origin? (Specit an, Puerto Ric	ty Yes or No- can, etc.)	14. Hace - Ar Black, W	nerican Indian, hite, etc.
Irs aff	by	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes X ☐ No If Yes, Give Year or Dates:		∏Yes 2M2 No Specif	fy:		Specify:	Black
2 hou	ted	15. Decedent's Educ		16a. Deced	lent's Usual Occupation		1	16b. Kind of Busine:	ss/Industry
e. "n	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. l	kind of work done during mo OO NOT use retired)]		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparmier. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents if tiem 27 is marked other than "naturel", or Items 23a or 28e-1 show any injury or other treumatic event, the Medical Examiliar is used to notified at once.	L	20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of	Dat		20c. Location - City	
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permit. Departrimporte any injury		V Danaid C.	Kunh	Ma	rch F/H We 500 wabash	st Ave.	Baltin	nore. Md	21215
		23a. Part1. Enter the disease, or complete shock, or heart failure. List only	cations that caused the death						Approximate Interval Between
Physician	1	Immediate Cause (Final disease or condition	Arch +	u	>				Onset and Death
/Medical	U	esulting in death)	Due t (or as a con- u	ence of):	4				SCAMOS
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pe tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury)	Due to (or as a consequ	ence of):					
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s affe	Certification;	4 Homidae	building, etc. (Specify,	,			City or Town,	, State)	
hour uner uner		29a. Certifier 1 Certifying Phys	sicien: To the best of my knowner: On the basis of examinati	vledge, death	occurred at the time, date a	and place, and	d due to the car	use(s) and manner	as stated.
To the Hospitel or Attending Physicien: The law requires that the death certification 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Aedicai	one)	and manner stated.	or anarotiff					
Vitt To COT	Σ	29b. Signature and title of certifier			29c. License number			d. Date signed (Mo	
1		1 / Von			100058	746)	ctobe	R1,2006
2x		01 1 00	mpleted cause of death (Item	23a) (Type,	Print) Fo Street	R < 1.1	00.0=	1100.00	100 21200
Str	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signati	nua A' ~20	- C STROKT	Dat	IVIORE	14-11-0V	1101 51 58.1
Regist		カウアカ こうり	nc &	Romer	- SO				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death 2.006 25 AM EINE UFRIEDE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death (USFITAL BAUTIMONE 25 N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ☐ M 2 🕱 F Yrs. 212-30-3742 17, Jan 1929 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4605 Forge Road 21128 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Education Elementary/Secondary (0-12) College (1-4or 5+) 09 n/a School Bus Driver Transportation/ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Louise (last name unknown by Edward **Betzler** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip and Cormant) 19a. Informant's Name/Relationship (Type, Print) Louise Theresa Mattheu/Daughter 15 Ayr Court, Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10/3/06 Metro Crematory Catonsville, Maryland 21. Signat of Funeral Service Lines f 22. Name and Address of Facility Dyan W. Clary Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sch line. 23a. Part1. Enter the disease, or complications that shock, or heart inlure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final disease or candition resulting in disetti Memic 0 VA Corinal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

Worke I

or 28a-f

the Medical Examiner must be notified at

other traumatic event,

ō permit. Page Department of Important: If any Injury or once. Funeral Director

Be Completed by

2

with the Maryland

filed within 72 hours after death the Hygiene. Stern then a thems 23s

2 should be finand Mental H

Pages 1 and 2 should be iment of Health and Menta tant: If Item 27 is marked

21215-0036

Baltimore, Maryland

Box 68760

P.0.

Division of Vital Records,

burial-transit the. attending pl cete has been signed by the page 2 should be detached

ð Be Completed

Physician/Medical Examiner Medical Certification: To

Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certifications to the Funeral Director.

D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

25. Was case referred to medical

5 Pending

investigation 6 Could not be determined

1 Yes 2-No

examiner's

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

Hospital:

28a. Date of Injury (Month, Day Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

1 Yes 2 No

26. Place of Death (Check only one)

24a. Was an autopsy performe

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1□ Yes 3□No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMONE M ZIZOZ

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

State Registrar

0574

Sel 32. Registrar's Signature

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

			State of Marylar Ob Per FH G8	Cei	tificat	e of l	Death				o.		
Physicia	an	Decedent's Name (First, Middle, Last)							Date of De Month	Da		3. Time of Death	
/Medic		ESTELLE HAI						PTEM	BER 28,2006 4c. County of Death		AUC:		
Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or Location of Death FREDERICK								
		F'REDERICK MEMORIAI 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)		r 1 Year	tf Under 24	Hrs. 8.	Date of Bi		REDERIC 9. Bi		
Funeral Director			м 210 г 78		Months	Days	Hours	Min. Ma	Month Di	^{ay.} 192	28 1	thplace (State or Foreigr ountry) ilberia	
the Maryland 28a-f ehow		10a. State 10b. County		ity, Town or Lo		. 1	. 1					10d. tnside City Limits 1 ☑ Yes 2 ☐ No	
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aryland 21215-0036 should be filed within 72 hours after deeth with the Maryland and Mantal Hygiene. marked other then "natural", or items 23a or 28a-f show martic event, the Associal Examinar most be notilised as		10e. Street and Number 8799 Tresurer A	renue		101. 21	p Code	21793			10g. E	- Liber	_	
items items	Funeral	THE MAINE STATES	Was Decedent Ever in L Armed Forces?	J.S. 13. \	Was Dece f Yes, spe	dent of H	ispanic Origin n, Mexican, P	? (Specify uerto Rica	Yes or Non, etc.)	0-	14. Race - Am Black, Wh		
036 urs afte	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes	2 No	Specify:			-	Specify: B1	ack	
15-0036	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced (Give	dent's Usu kind of w	al Occup	ation during most of	f working		16b.	Kind of Business	s/Industry	
2121 I within liene. I then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired) Teacher					Education			ion	
nd 2	Be	17. Father's Name (First, Middle, Last)									laiden Sumame)		
ryla nould b d Meni	1º	David B.S. Greenf 19a. Informant's Name/Retationship (Typ.		10b Mailie	a Addros	e (Street					gomery or Town, State,	Zin Code)	
Mal nd 2 sl slth an 27 ls r r traur		Carmelita Harris/			•		Ave.			-			
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Balti permit. Departm Importa eny Inju		21. Signature of Funeral Service License	Rapola	11/1			ss of Facility				uary, I	nc. 20002	
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/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):									
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ion inding ath. r: Afte	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation					Work? 1 □ Yes 2 □ No						
Division of Vital Records, I or Attending Physician: The law requires that cleath. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	At home, farm, street, factory, office ecify)					 Location (Street and Number or Rural Route Number, City or Town, State) 				
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o the o the omplei	Med	29b. Signature and title of certifier	and manner stated.		29	9c. Licens	e number			29d. D	ate signed (Mor	nth, Day, Year)	
P 5 P 0		Suhh mo				Do	0634	98		9	12810	6	
4		30. Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type,	Print)						-		
0.1	te	31. Date filed (Month, Day, Year) OCT 0 5 20	32. Registrar's Sign	nature	f is								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #19b&34a Per Phy&FH Centificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Jones Month **Physician** ara 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner Roseda ranklin Bal Square If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 091/27/ 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 25√F Yrs. 59 214-50-5250 Director NC Usuel Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "naturel", or Items 23e or 28e-f show other treumatic event, the Medical Examinar must be redified at 1X Yes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai USA 14. Race - American Indian, Black, White, etc. 7846 HILLSWAY AVENUE 21234 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "naturel", or Itei 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █No Specify: Specify: BLACK þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BALTO. COUNTY Elementary/Secondary (0-12) College (1-4or 5+) TEACHER SCHOOL SYSTEM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 K.C. CRAWLEY MABEL MC CAIN 19b. Mailing Address (\$reet pro Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 nent of Health a ent: If item 27 is MABEL CRAWLEY/MOTHER 6601 PARKWAY APT. 1C, DUNDALK, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Importent: If it eny injury or o Burial 2 Cremation 3 Removal from State KING MEM. PARK 10/06/2006 BALTO., MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS FUN. of Funeral Service Licensee 21. Signature HOMES, 1701 LAURENS ST., BALTO., MD 21217 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arrhythmia **Physician** immedia to /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medicai as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 XX 2 1 No 1 🗌 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Cthen 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 142232 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2112 Dundalk SCUT + eeser 31. Date filed (Month, Day, Year) 32. Registrar's Elgnatur

DHMH 17 Rev 1/2001

State

Registrar

0 OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 31573 Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) October 2006 Physician 11:03 P M Robert O. Johnston /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Westminster Carroll 153 Wampee Ct. 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 1/10/1924 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number **Funeral** Hours 1**2** M 2□ F Months Days 82 Yrs. 234-24-4390 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State ir than "natural", or Itams 23e or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No MD Westminster Director Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21157 U.S.A. 153 Wampee Ct. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ØYes 2 □ No If Yes, Give Year or Dates: 1943-46 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: White ۵ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Truck Driver/Dispatcher Trucking permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier Important: If Item 27 is marked other th any injury or other traumatic avent, IDS 20028. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nora Myers John C. Johnston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 153 Wampee Ct. Westminster, MD 21157 Robert J. Johnston - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10/7/2006 Loudon Park Cem. Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, MD 21228 21. Signature of Fyneral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) -IVRV Zmonms **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Due to (or as a nonsequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit physician and Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ page 2 should be Bens1 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performed! 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To Alter this 27. Manuar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 5 Pending 1 Matural after death.

Director: Alt
in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Funeral [Hospital completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200599993 5,2000 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) dunc Apel mo Sporer Suite 307

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) 2006 5

32 legistrar's Signature

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Barbara J. James	1- For State	tate of Maryland	/ Department Certificate	of Health and Me of Death	ental Hygiene	Reg No 20	06 3157
Physician/	Registrar 1. Decedent's Name (First, Mid	dle,Last)			2. Date of Month		3 Time of Death
Medical Examiner	BARBARA	J. JAMES			Octobe	er 2, 2006	1937 hrs
	4a. Facility Name (if not institute Prince George's Hos		r)	4b. City, Town, or Locati Cheverly	on of Death	4c. County of Prince Ge	
Funeral	5. Social Security Number	6. Sex 7. A	age (In yrs. last birthday)			of Birth (MM/DD/YYYY)	Birthplace (State or Foreign
Director	220-84-0968	1 M 2 X F	45	Yrs. Months Days Ho	ours Min. 07/1	8/1961	Country) MD
ž:	Usual Residence of Decedent 10a, State 10b, Count	v	10c. City, Town or Lo	cation			10d Inside City Limits
d now any		ce George's	Capital	Heights			1 XXYes 2 No
the Maryland a or 28a-f sh lifted at once	10e. Street and Number			10f. Zip Code		10g. Citizen of What	t Country?
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. taut: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	9508 Acorn Par	k Street		20743		U.S.A.	
r death with or items 23 must be no	11. Marital Status 1 Never Married 2 XX	12. Was Decede Armed Force	s?	Was Decedent of Hispanic If Yes, specify Cuban, Mex			American Indian, 8lack, etc.
er deat , or it. Fur		1 Yes	2 XX _{No}	Yes 2XX No spe	ecify:	Specify:	White
urs afte amine amine d by	15. Decedent's Education (Sp	or Dates:	ompleted) 16a. Dece	dent's Usual Occupation (G g most of working life, DO N	Give kind of work done	16b. Kind of Busi	ness/Industry
6 an "ny cal Ex	Elementary/Secondary (0-12	2) College (1-4 c	or 5+)	emaker	10 1 000 10 mody	Own Ho	OMA
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Grade 10 17. Father's Name (First, Midd	le. Last)	HOME		other's Name (First, Mid		Jille -
215. be filed and Hy will Hy ent, the orthogonal Be C	Owen Louis Lus				ildred Hutc		
21 hould the Mer is mar utic ever	19a. Informant's Name/Relatio		13	iling Address (Street and			State, Zip Code) hts, MD 20743
, ME and 2 s salth at	Charles Russel	.I James, Jr.		position (Name of cemeter)			City or Town, State
altimore, mir. Pages I ar partment of He. portant: If ite ury or other tr	1 Burial 2 X Cremat	ion 3 Removal from	State	rotherplace) undel Cremato	ory 10/7/20	odento	n, Maryland
Baltimo permit. Page Department o Important: injury or oth	4 Donation 5 Other 21. Signature of Euneral Servi			2. Name and Address of Fa Donaldson Ful			1
Ba pern Dep Inju	Gy 5 6	1	/ M00770	313 Talbott A	Avenue Lau	rel. Marvla	and 20707
Physician /Medical	23a. Part I. Enter the disease, failure. List only one cal	ise on each li n e				ry arrest, shock, or hear	rt Approximate Interval Between Onset and Death
Sxaminer	Immediate Cause (Final dise or condition resulting in death	se a. Narcotic Due to (or as a co		oxycodone) into	oxication		333
·	Sequentially list conditions,	b					
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cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit	1 LINBENDED	d AMENDED .		5 NE 000	10/10/00 100		
50, te be execut nysician and burial - tra		1	tem#23a,27,286 come of pregnancy	a-f,perME,g860,	10/12/06 11	23d. Date of d	delivery
6870 ertifica ding pl	23b. Was decedent pregnant i past 12 months?	n the 1 Live birth	2		ctopic pregnancy	Month	Day Year
of Vital Records, P.O. Box 6876 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phytuneral director, page 2 should be detached for use as the law to Boromaloted by Physician IM	1 Yes 2 No 9			Other (Specify)			
P.O. Es that the can gened by the detached	Part II. Other significant con	ditions contributing to de	eath but not resulting in	the underlying cause given	in Part I 23e.		bute to the cause of death?
S, P.(Probably 4 Unknown Vere autopsy findings available
(ecords, The law requires ate has been sig						autopsy pr	rior to completion of cause of eath?
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ital iician: s certif	examiner?	Liennitel:	atient 2 🗸 ER/Outpa	Othe		5 Residence 6	Other:
Division of Vital Records, rater derivations of Vital Records, rader death. The law require and in the reminion of the funeral director, page 2 should be a still the funeral director, page 2 should be a still the funeral director.	27 Manner of Death	28a. Date of (Month, D	Injury 28b. Time		Work? 28d. Des	scribe how injury occurre	ed
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Division o spiral or Attending nours after death meral Director: After filled in by the fune	3 Suicide 6 X	Could not be 28e. Place of		street, factory, office buildi	ng, etc. 28f. Loca	ation (Street and Number own, State) 9508 Ar Mar Boro Mi	er or Rural Route Number, City corn Park Street
ospital hours unceral		g Physician: To the best of	House	occurred at the time, date a			
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	(Check only one) 2 Medical l	Examiner: On the basis of and manner state	examination and/or inve	stigation, in my opinion, dea	ath occurred at the time	, date and place, and di	ue to the cause(s)
To To COI	29b. Signature and title of ce			29c. License nu			ed (Month, Day, Year)
	Janot Bouth	all, MD		O.C.M.E	:	October 3,	ZUU6
	30. Name ress of per Pamela E. Southal		of death (Item 23a) edical Examiner	111 Penn Street, B	altimore, MD 212	01	
Sta	51 51 101 U S V		strar's Signature		, , ,		
Registr	OCT 0	5 2006	we It for	parli			

			1 - For State Registrar	State of Maryla	nd / Depa <i>Ce</i> a	artment of H	ealth and N Death		ene200	5 3 1 5 7 5
	Physici /Medic	4	Decedent's Name (First, Middle, Last)		W. Kelle	er		2. Date of Death Month	Day Year 28 200	- I S' - A 14
(Examir		4a. Facility Name (If not institution, give: ST. Agnes Ho	4 1		46. City, Town, or Baltim			4c. County of De	
	Funeral Director		244-14-5594	7. Age (In yr	s. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jul 18,	Year) (irthplace (State or Foreign Country) So. Carolina
	Marylend -f ehow lied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland	10c. (City, Town or Lo		altimore			10d. Inside City Limits 1 □ Yes 2 □ No
	h with the	ai Director	10e. Street and Number 615 Nottingham Road			10f. Zip Code	21229	10	g. Citizen of What (Country? J.S.A.
36	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow the Mudical Exam ar must be collified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ ¥es 2 ☐ No If Yes, Give	1942	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (Sin, Mexican, Puerto Specify:	pecify Yes or No- Dican, etc.)	14. Race - An Black, Wh Specify:	nencan Indian, nite, etc.
215-00	nin 72 hour In "natural" Mudical Ex	Completed b	15. Decedent's Edu (Specify only highest grade	Year or Dates: cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	uring most of wor.	king	6b. Kind of Busines	er Truck Co.
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Maryla	d 2 should I h and Meni 7 is market traumatic	2	Williar 19a. Informant's Name/Relationship (Ty Mary Keller Wife	n Keller rpe, <i>Print</i>)		ng Address (Street a		ral Route Number,	City or Town, State	, Zip Code)
Baltimore, I	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Items 23e or 28e-f ehow empty injury or other traumatic event, Item Mudical Examinat must be notified at ance.		20a. Method of Disposition 1 Surial 2 Cremation 3 F 4 Donation 5 Other (Specify)		. Place of Dispo cemetery, cre	osition (Name of matory or other place	9)		20c. Location - City	or Town, State
Baltii	permit. P Departm Importar eny injur		21. Signature Huneral Service Lica's	A. Este		2. Name and Addres	s of Facility Brothers Fun	eral Service, Baltimore, Mo	P. A. 121217	1919
8760,	Physician and // / / / / / / / / / / / / / / / / /	ıi Examiner	23a. Part1. Enter the displase, or complishock, or heart fail fee. List only or immediate Cause (Find disease or condition resulting in death) Lequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Gastric Due to (or as a cons	Cance equence of): tract equence of):			or respiratory arre	ist,	Approximate Interval Between Onset and Death
P.O. Box 687	Th, law requires thet the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	etal death 3	□Ectopic pregnancy			23d. Date of o	delivery Day Year
	juires thet t signed by Ild be detai	d by Ph	Part II. Other significant conditions con		resulting in the u	f	on in Part I.			to the cause of death?
Division of Vital Records,	The law require te has been si age 2 should i	Completed						24a. Was ar autops perform 1 Yes 2	y prior t	autopsy findings available o completion of cause of ?
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o uois	To the Hospital or Attending Physicien: The I within 24 hours efter death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page		27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	rat √? ∕es 2 □No	28d. Describe ho	w injury occurred	
Divi	ital or Att urs efter d rel Direct lled in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Al building, etc. (Spe	ecify)			City or Town	, State)	Rural Route Number,
	To the Hospital within 24 hours e To the Funeral I completely filled	Medical	(Check only 2 Medical Exami	ner: On the bast of my hiner: On the basis of exam and manner stated.	nowledge, deal ination and/or in	ivestigation, in my or	oinion, death occu	rred at the time, da	ate and place, and d	fue to the cause(s)
•	5 1 kg 2		29b. Signature and title of certifier Validham	Medic	al Inter	n P = 3	Lo 655	S	ept 28	No 6
	1.4		30. Name and address of person who co	KHANI	900	caton AV	e Bath	imale 5	21229	
	Sta Regist		31. Date filed (Month, Pay, Year) 5	2006 32. Registrar's Sig	gnature	Coale				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 5 For Stete Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 8 25 PM Garrett Keene 26 2006 SE PT /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HEALTH CARE **Baltimore** ST. AGNES BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 🗆 🗱 2 🗆 F 218-58-7700 52 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location worde ! permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mental Hygiene. 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Mother's Name (First, Middle, Maiden Surname) Elbert Smith Evelyn Keene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1900 Boone Street Baltimore, Maryland 21218 Yvonne Lucas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/04/06 Windsor Mill, Md. 4 Donation 5 Other (Specify) King Memorial Park 21. Signatur of Funeral Service I cen e 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner REBRO VASCULAR ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed FIBRILLATION TRIAL RONIC physicien and Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š DIOMYOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? hes certificate 1 Yes 2 No 1 Yes 2 Ū√No 25. Was case referred to medical Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year) 0 5 2006

kang

29b. Signature and title of certifier



STAFF PHYSICIAN

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760 SARRETT

Records,

Division of Vital

D0059554

29d. Date signed (Month, Day, Year)

26,2006

HEALTH CARE

LUCIUS 215-0036 Baltimore, Maryland Known

P.O.

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 200 31577 1 - For Stete Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Way 2344 29 Walter PRF UCIUS 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Baltimore Hospita1 Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 0 M 2□F 9074 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23s or 28s-f show the Madical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director altimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 3610 2120 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No If Yes, Give Year or Dates: W ∏ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene 9 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 end 2 should be Health and Mental ၉ Leeper atterson arlic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3610 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ō 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Depertment of Important: if eny injury or once. 4 □ Donation 5 □ Other (Specify) 10 4/06 22. Name and Address of Facility Chatman 21. Signature of Funeral Service Licepsee Harr Funeral Home nd Baltimore irr 5240 Preisperstown Md 23a. Part. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hemorrhage Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cance Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner andk The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical as the nse. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, entension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown areurysm 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2. No 1□ Yes or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😿 No 2 ER/Outpatient 3 DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person ŧ 4090A, MI YLVANUS

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 5 2008

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No 2 U U 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 10:35 AM Helen B. Lee September 26, 2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 8037 Inverness Ridge Road Potomac Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 382-28-820 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan entent of Heelth and Mental Hygiene.

crtant: If item 27 is marked other then "naturel; or items 23e or 28a-1 show injury or other treumatic event, the Medical Exaction must be notified at 1 ☐ Yes 2 ☐ No Director MD Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 8037 Inverness Ridge Road USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status I □ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: asian δ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 12 teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lee Kim Fong Chow You Leon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1437 N. Cleveland Avenue Chicago, IL 60635 Kimberly Stolze/daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 X Donation 5 ☐ Other (Specify) State Andron Faboard 655 W. Baltimore Street god Baltimore, MD 21201 or emple Approximate Interval Between Onset and Death 23a. Part1 Enter the disea , or on mean failure. List only is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Juse (Final disease or condition resulting in death) **Physician** raino /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ Examiner the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached fo 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2 🗌 No 3 ☐ Probably 4 ☐ Unknown peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has all director, page 2 autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Medical Certification; To Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) Ave 5530 Wisconsi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	1,104	State	of Maryla		partmen ertificat			and M	F	leg. No.	006	315	
	Physici	an	Decedent's Name									2. Date of Dea Month	Day	Year	3. Time of	
	/Medic	al	John Ru 4a. Facility Name (If			(number)		4b. City.	Town, or	Location of		Septemb		ounty of Death	3:25	AM "
	Examin	er	Stella :		•	,		,		ville			В	altimo	re	
	Funeral Director		5. Social Security No. 048-30-7		6. Sex 1⊠M 2□		rs. last birthda	Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day Feb 17,	, Year)	9. Birth Cou	place (State ontry)	or Foreign ut
	D		Usual Residence of	Decedent		100	Oib. T	1							10d. Inside C	
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SEPTEMBER 23, 2006 3:25 Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f ehow apply injury or other traumatic event, ite Medical Exartment must be notified at once.	þ	1 ☐ Never Marri		If Yes Year	es 2 □ No , Give or Dates: 16	2-66	1 ☐ Yes	2 X No	Specify:			S	pecify: W	nite	
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State of Maryland / Department of Health and Mental Hygiene 005

				State of Maryl	and / Depa <i>Cei</i>	artment of H <i>rtificate of</i>	dealth and Death		gien 2 006 Reg. No.	31580
	B)		1. Decedent's Name (First, Middle, Last)	,				2. Dete of De Month	eeth Dey Ye <i>a</i> r	3. Time of Death
	Physici- /Medic		Jeanne B. L	indseu				Septem	ber 21, 20	06 7:10 PM
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9s 1.	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic avant, The M ODE®.		20a. Method of Disposition	20	 Place of Dispo cemetery, crer 	sition (Neme of natory or other pla	ce)	Date	20c. Location - City of	r Town, State
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 24a per verb 8860 10-5-06 vt. State of Maryland Department of Health and Mental Hygien 0 0 6 31581 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** -U13 Lopez 1:55PM 09 29 2006 /Medical 4c. County of Peath 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Joseph Ritchie Hospice Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1**X**M 2□ F 584.72. lde13 Months Days Hours 50 Puerto Rico 07.10.1956 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h Count 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-1 show air injury or other traumatic event, the Medical Exportment he notified at OREs. NIA MD Baltimore 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21239 1517 Winston Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No Specify: Puerto Rican Specify: Puerts Rican þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mechanie tutomotive 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Guillermina Ramos Aurelio Lopez 3016016 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1517 Winston Avenue Hamilton/ Sister Balto. MD Lourdes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Greenmouth Overnatory 10/04/06 Baltmore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of collity Vallahn C. Greene Funeral Service 4905 York Road Balto MD 21712 21. Signature of Funeral Service Licensee len Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CIRRHOSIS pf Physician' /Medical Due to (or as a consequence of): Examiner STALB Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury test initiated executes) Due to (or as a consequence of): Examiner ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit CHRove Loy that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 (Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier t Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier de D14221 B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 223 B. BLWD BOCT A. 12/2024 win 32. Registrar's Signature 31. Date filed (Month, Dav. Year) State OCT 0 5 2006 Registrar MANDONO

State of Maryland / Department of Health and Mental Hygiene 20061 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** October 1, 2006 Betty Mae Latham 04:15 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 405 Audrey Avenue Brooklyn Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Months Days Hours Min Yrs. 291-24-8399 78 Director 05/20/1928 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 405 Audrey Avenue 21225 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No white Specify: δ 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If item 27 is marked other ti
eny injury or other treumatic event, IIIs
page. homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anthony McNair Pearl Sypolt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Betty V. Reynolds /daughter 512 St. Martins Lane; Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 10/05/2006 Brooklyn Park, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 101357 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. oscle Ro Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,~ Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Feta! death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 20 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient s after death.
I Director: After this ce d in by the funeral direc Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√No ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funstal Direct 4 Homicide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10-2-06 1)21716 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add JOHY Annapolis Rd. Baltimore, HD 21227 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 5 2006 Registrar

amend i tem 1 per doc 2860 10-5-06 yrd Mental Hygien 2006 31583 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Physician Michael D. Mott Sr. xptember 2:00 A M 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Medual Center Mary land If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**∑**M 2□F 47 59 Director 219-72-6610 18 MD 04 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f show other treumatic event, the Medical Examiner must be notified at XXYes 2 No Director Baltimore MD NA 10e Street and Number 10f, Zip Code 10g. Citizen ol What Country? ö U.S.A. 4128 North Forest Park Ave #1 21207 or items 23a death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or Ite 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Mechanic 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Barbara E. Webb Troy L. Mott Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 19a. Informant's Name/Relationship (Type, Print) 4128 North Forest Park Ave #1, Balto, Md Barbara Douglas-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 20a. Method of Disposition Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit, Pag Department Importent: It any injury or King Memorial Park 10/5/06 Randallstown, Md 21. Sign tule of Funeral Service Licenses 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Svere tracranial **Physician** IM ow has le hours /Medical Due to (or as a consequence of) Examiner rebral aneuryom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence ol): burial-P.O. Box 68760, physician Physician/Medical the as the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
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1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) detached 9☐ Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 99 cate hes been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy certificate Division of Vital 1 ☐ Yes 2 0 No 1 ☐ Yes To the Hospitel or Attending Physician: After this certification funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Impatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA 28a. Date ol Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation hours after death. Director: / 6 ☐ Could not be 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) in by determined 4 | Homicide within 24 hours a To the Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0063044 2000 s of person who completed cause of death (Item 23a) (Type, Print) South Allan Ohilp Greene ar Date filed (Month 32. Reostrar's Signature 31

DHMH 17 Rev 1/2001

State

Registrar

5 2006 06-07354 G

6-07354	Please Type or Print in Black indelible ink	Landana -	
Sarry McAphee	State of Maryland / Department of Health and Mental H		- 0
	1- For State Certificate of Death Registrar	Reg. No. 2006 315	<u>1 0</u>
Physician/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year Sentember 30, 2006 957 hrs	
Medical Examine	Garry Norman McAbhee	September 30, 2000	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat		
	Johns Hopkins Bayview Medical Center Baltimore	N/A	
Funeral	5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Mir		
Director	035-36-5198 1XM 2 F 52 Yrs. Williams Days Tours Williams	08/20/1954 Country) RI	
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aryla 8a-f at or	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?	
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d wij	17. Father's Name (First, Middle, Last) 18 Mother's Nam	ne (First, Middle, Maiden Surname)	
21215-0036 and be filed within 7 Mental Hygiene marked other than e event, the Medica		ne E. Whitaker	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene ten 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Oliver McAphee, Sr. Ernestir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	r Rural Route Number, City or Town, State, Zip Code)	
MD 2 sho bh and 27 is	Angela C. Chambers/Daughter 2906 Louise Avenue Ba		
nore, MD 2 gges I and 2 shou nt of Health and N t: If item 27 is u other traumatic	20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c Location - City or Town, State	
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Baltimore, MD 2 permit. Pages Land 2 shou Department of Health and N Important: If item 27 is u injury or other traumaric		Leonard J. Ruck, Inc.	
Balti permit. Departu Import injury	SC 1/2/// 1571	Baltimore, MD 21214	
Physician	23a. P. 1. Enter le il ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. Coaine intoxication	c or respiratory arrest, shock, or heart Approximate Inte	
/Medical	-Att	Between Onset a Death	and
Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		
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Div	Suicide 6 A Could not be determined (Specify) other—scene	28f Location (Street and Number or Rural Route Number or Town, State) Baltimore, MD Fastbury Road	
Hospital 24 hours Funeral stely fille			
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring the completely filled in by the funeral director.	one) 7 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d at the time, date and place, and due to the cause(s)	
To with	and manner stated 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)	
	O.C.M.E.	October 1, 2006	
	30. Name and address of person who completed cause of death (Item 23a)		
10	30. Name and address of person who completed cause of death (herrizolar) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201	
	22 Peristrar's Signature		
Sta	To 31. Date filled (Month, Day, Year)		

			1 ← For State Registrar	State of Ma	ryland /	Depart Certi	ment of H	lealth ar Death	nd Me		iene ()	06	31585
3"	Physici	an	1. Decedent's Name (First, Middle, Last) MARGARET		044					Date of Deal Month	Day	Year 2006	3. Time of Death 4 - 35P M
	/Medio Examin		4a. Facility Name (If not institution, give s		/		b. City, Town, or					ity of Death	
*	Funeral Director	100	5. Social Security Number 6. Sex	7. Age	(In yrs. last b		If Under 1 Year Months Days		Hrs. 8	3. Date of Birth Month, Day 09/18/1		9. Birthp	lace (State or Foreign htry) y l vani a
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, To		tion				-	11	Od. Inside City Limits
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Baltimore,	Pages 1 nent of He int: If Item iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State	ceme	of Disposit etery, crema ens of	ion (Name of tory or other plac -aith		Dat 0/05/2		20c. Location Baltimo	•	wn, State
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Division	rie f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.		, farm, stree	t, factory, office		28	3f. Location (S City or Tow		mber or Rura	al Route Number,
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	To the Vithin 2 To the Complet	Me	29b. Signature and title of certifier				29c. Licens			1	9d. Date sign		
	(Suple				000	531	52) (017	Suc	2006
	5		30. Name and address of person who co		ath (Item 23:	a) (Type, Pr	o Sen	hers	o R	e Su	ele 1	100	9 200 6 9000 6
	Sta Regist		31. Date filed (Month, Day Year)	20 32. Registra	r's Signature	10 m	Grante I					V	

				For Stete Registrar		State of	Marylan	d / Depa	artment <i>rtificate</i>	of H	ealth Death	and N	lental Hy	giene	2006	3158	36
	T			Decedent's Name	(First, Middle,	Last)							2. Date of De	aath Day	/ Yeer	3. Time of Dear	th
		Physicia /Medic		Emilie M	lartine	k							Septemb	er 1	9, 2006		2M
		Examin		4a. Facility Name (If	not institution,	give street and num	ber)		4b. City, T					4c.	County of Dear	1	
				The Wes	Ley Hom	e 6. Sex	'. Age (In yrs.	last hirthday	If Under 1		imore		8 Date of Bir	rth	9 Rid	nplace (State or For	reian
		Funeral Director		213-26-54		1 ☐ M 2 🔀 F	95	Yrs.		Days	Hours		8. Date of Bir (Month, Da Nov 24	y, Year) 19	Co	untry) ch Rep	g.,
		-		Usual Residence of I	Decedent									,			
		irylan show	_	10a. State MD	10b. County		10c. Cit	y, Town or Lo								10d. Inside City Lin 1√2 Yes 2 □	
2		the Marylar 28e-f show	Director					Balti		2		_		10a Citi	izen of What Co	71	
P		with th		10e. Street and Num		4			10f, Zip (222			iog. Citi		unity	
0		72 hours after death with the Maryland neturel; or items 23e or 28e-f show disel Exant per must be notified at	Funerai	2211 W. 1	Rogers	12. Was Dece	dent Ever in U	.S. 13.	Was Decede		209 ispanic Or	rigin? (Sp	pecify Yes or No Rican, etc.)	0-	USA 14. Race - Ame		
50	(0	riter d	표	1 Never Marrie	d 2 Marrie	Armed For	ces?						Rican, etc.)		Black, Whit		
0	5-0036	reft, o	þ	3 XWidowed 4	Divorced	If Yes, Give Year or Da	tes:		1 🗆 Yes 2	X NO	Specify	·:			Specify: wh	ite	
	5-0	72 h	Completed	(Special	15. Decedent's fy only highest	s Education grade completed)		(Give	dent's Usual kind of work DO NOT use	done o	durina mo:	st of work	king	16b. Ki	ind of Business	Industry	
@ 1	2121	within lene. than	mp	Elementary/Secon	dary (0-12)	College (1-	4or 5+)		ccount					f.	inancia	1	
0	d 2	filed Hygid Sther ent, I	Be Cc	17. Father's Name (/	First, Middle, L	ast)		0	ccoun	Lant		er's Nam	e (First, Middle				
30	<u>a</u>	ld be lental rked o	To B	Frantise	k Kucha	ar					M	arie	Kuchar	ova			
2	ary	2 should and Men is marke eumatic		19a. Informant's Na	me/Relationshi	ip (Type, Print)		19b. Maili	ng Address	(Street a					r Town, State, 2	(ip Code)	
1	Σ	and 2 ealth n 27 i		Irene Vi		laughter							ltimore	-			
4002/61/6	altimore, Maryland	Pages 1 and 2 should be filed within 72 hours after death with the Maryla neut of Health and Mental Hygiens, or items 23a or 28e-f show int: if item 27 is marked other than "neturet", or items 23a or 28e-f show int: if item 27 is marked other than "neturet", or items 23a or 28e-f show int or other treumatic event, it a Medical Examination must be notified at		20a. Method of Dispo 1 ☐ Burial 2 ☐ 1 ☑ Donation	Cremation	3 □Removal from S ecify)	State 20b. F	Place of Dispo cemetery, cre			j		Date		ocation - City or		
~	Balti	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Eur	eral Service L Dna Ld S	Wade /	7 90501	$c = \begin{vmatrix} S^2 \\ S^2 \end{vmatrix}$	2. Name and tate A altimo	Addres nato	ss of Facil Omy E	Board 2120	l 655 W.	. Bal	timore	Street	
0				23a. Part1. Enter the	e disease, or o	complications that cannot one cause on ea	used the deal							arrest,		Approximate Interval Between	1
	4	Physician		Immediate Cause (I disease or condition	inal	ENT	ST	AGE	ALZ	HU	MEX	25	Demo	NTTI	4	Onset and Death	a
	1	/Medical Examiner		resulting in death)		Due to (or as a consec	quence ol):									
expired	н	Examine	_	Sequentially list con	ditions,	b	or as a consec	occupante talle.						_			
=	-	led Isit	nine	Sequentially list con ir any, leading to im- cause. Enter Under Cause (Disease or i	tying njury	500 60 (n as a consec	addition of the									
Ex		cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) L		C. Due to (or as a consec	uence of):									
	8760	e be e				d											
\-	9	tificat ng phy as th	ledi	 													
MARTINEK	S. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 i 1 □ Yes 2 □ 9 □ Unknown	months?		nth 2 ☐ Feta ant at time of d	aldeath 3[⊒Ectopic pre ⊒ Other <i>(spe</i>						23d. Date of de Month	ivery Day Year	
1-	P.0	hat the			cent condition	ns contributing to de	ath but not res	sulting in the u	underlying ca	use give	en in Part	l.	23e. Did	tobacco u	use contribute to	the cause of death	1?
46	of Vital Records,	law requires that as been signed E 2 should be deta	Completed by	HYPER	72-NS10		DURTER	NSIVE	CA	RDI		Sail	AR 10	Yes 2	XNo 3□P	obably 4 Unkn	own
2	000	aw rec s bee 2 shou	plete	DISEN	KSE	,							24a. Was	s an	24b. Were a	topsy findings avail	lable
	Re	i icien : The lav certificate has rector, page 2	mo										perf	ormed? 20 No	death? 1 ☐ Yes	2 □ No	
W	ita	ien: ortifica ctor, p	Bec	25. Was case referr	ed to medical						26. Plac	e of Dea	th Check on	-			
7	<u>></u>	hysic his ce Il dire	To	1 ☐ Yes 2				ER/Outpatie		-	4/L N	lursing H			6 ☐Other (Spe	cify)	
EM14		ing P	ino.	27. Manner of Death 1 Natural	5 Pending		of Injury h, Day Year)	28b. Time of Injury	M 28	Bc. Injun Worl	yat k? Yes 2.[7No	28d. Describe	now inju	ry occurred		
w	Division	death death stor:	icat	2 ☐ Accident 3 ☐ Suicide	investig 6 ☐ Could n	ot be 200 Blace	of Injury - At h	ome farm st			163 20	1110				ıral Route Number,	-
	Σį	after Direct Jin by	Certification;	4 🗌 Homicide	determi	ned buildir	ng, etc. (Speci	fy)	,,				City or To	wn, State	e)		
		To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)	Certifying 2 Medical E	g Physicien: To the exeminer: On the ba and mann	sis of examina	owledge, dea ation and/or in	th occurred anvestigation,	at the tin	ne, date a pinion, de	and place eath occu	, and due to the rred at the time	cause(s) and manner a d place, and du	stated. to the cause(s)	
		ro the	Me	29b. Signature and	title of certifier	0 0	-		29c.	Licens	e number			29d. Da	te signed (Mon	h, Day, Year)	
		- > - 0		17 Colin	XZ	Kalun	W.D		I)-1	942	25		9/	20/20	06	
				30. Name and addre	ess of person v	who completed caus	e of death (Ite						2		4 -	0.15	
				ROBERT	É. 1	LOBY M.L), - 22/	1 W.1	20GER	5	AUE	t.	BALTIM	ORE,	MD	41209	
		Sta Regist	ate rar	31. Date filed (Mont	TO 5	2006	egistrar's Sign	A STATE OF THE STA	and I								

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68760,
Вох
P.O.
Records,
Vital
of
Division

		Please Type or Pring State of Management 1 - State Registrar	aryland / Dep		ealth and Men	-	2008	31587
Physi /Med	lical	1. Decedent's Name (First, Middle, Last) BETTY MILLER 4a. Facility Name (If not institution, give street and number)		4h City Town or		Date of Death Month Di PTEME	Year	3. Time of Death
Exam	o obelone II	Good Samaritan Hospital 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday	Baltin	ore	Date of Birth	N/A 9. Bit	rthplace (State or Foreign
Directo	r	236–50–7667 1	Yrs. 10c. City, Town or L		No	ov. 25,1	934 Wes	st Virginia 10d. Inside City Limits
ith the Mary or 28a-f sho	Director	Maryland N/A 10e. Street and Number	Baltimo	10f. Zip Code		10g. C	itizen of What C	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Marical Examinat must be notified at	by Funeral Director	916 W. 38th Street 11. Marital Status 1 Never Married 22 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 1 2 8 2 3 1 1 2 8 2 3 1 2 8		212 Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2XXIII	spanic Origin? (Specify n, Mexican, Puerto Ricar Specify:	Yes or No- n, etc.)	USA 14. Race - Am Black, Whi Specify: V	erican Indian,
I within 72 houlene. Iene. r than "natural ine Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	edent's Usual Occupa e kind of work done d DO NOT use retired, nemaker	ition uring most of working	16b. I	Kind of Business	
nould be filed I Mental Hyg narked other natic event,	To Be C	17. Father's Name (First, Middle, Last) Dolan	1		18. Mother's Name (Fire			Ti- Co to
is 1 and 2 shot Health and Item 27 is in other traum		19a. Informant's Name/Relationship (Type, Print) Rachel Miller Granddaugh 20a. Method of Disposition	nter 916 V	W. 38th St	reet Balti	more, Ma		21211
permit. Page Department of Important: If any injury or	in the second	1 ☐ Purial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses	Maryland	d Veterans	10/05/2			orest, MD
Physiciar /Medica Examine	1	Sequentially list conditions.	the death. Do not ene. A S C V a consequence of):	3631 Falls	ROAC, BALT	piratory arrest,	Maryland	Approximate Interval Between Onset and Death
ficate be executed physicien and s the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events c.	a consequence of):					
w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	olivery Day Year
equires that t sen signed by ould be deta	þ	Part II. Other significent conditions contributing to death b	ut not resulting in the o	underlying cause give	n in Part I.			o the cause of death?
in: The law r riicete has be or, page 2 sh	e Completed	25. Was case referred to medical				24a. Was an autopsy performed?	death?	utopsy findings available completion of cause of s 2 No
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificete has been signed by the attending physicie completely filled in by the funeral director, page 2 should be detached for use as the bur	Certification: To Be	examiper? Yes 2 No Hospital: 1 Inpatie 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Stricted 6 Could not be	y Year) 28b. Time of Injury	of 28c. Injury Work M 1 1	at 28d. ? 28d. 2 No	5 Residence Describe how inju	ury occurred	ecify) Iural Route Number,
Hospitation 24 hours aft Funeral Di stely filled in	Medical Cer	29a. Certifier (Check only one) ** Certifying Physicien: To the best 2 Medical Examiner: On the basis of and manner street.	of my knowledge, dea f examination and/or in	ith occurred at the tim	e, date and place, and o	lue to the cause(s) and manner a	s stated. e to the cause(s)
To the vithin To the comple	Mec	29b. Signature and title of certifier	. 7.	29c. License	SAMAR	29d. D 5 t	ate signed (Mon	th, Day, Year)
			- Andrews	- Control		1		1

Please Type or Print in Black Indelible Ink
of Maryland / Department of Health and Mental Hy

ucy ivieiton	State of Maryland / Department of Health and Mental Hyglene 1- For State Certificate of Death Reg. No. 2006	3158
Physician/ ledical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	Time of Death
	4a. Facility Name (if not institution, give street and number) Howard County General Hospital 4b. City, Town, or Location of Death Columbia 4c. County of Death Howard	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplated Months Dave Hours Min Foreign	North North
ow any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10	d Inside City Limits Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.		
ith the M 23a or 2 notified		Indian Block
s after death with rial", or items 23 ainer must be no by Funeral	3 X Widowed 4 Divorced if res, give rear 1 Yes 2 X No specify: Specify Will Let	
2 hour "natu		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	William Tate Bathburn Laura E. Wyatt	
MD 21 Id 2 should the and Me in 27 is ma aumatic ex	19a. Informant's Name/Relationship (Type, Print) Linda Corcoran / Granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 205 Drum Avenue South Pasadena, Maryland	
Baltimore, Memit Pages I and Departite Pages I and Department of Healt Important: If item injury or other trans	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify. 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory 10/5/2006 Baltimore, Ma	
Baltin permit Departm Importa	21. Segnature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, 4001 Ritchie Highway Baltimore, Marylan	P.A. nd 21225
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	approximate Interval Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of):	
led nsit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of): Due to (or as a consequence of):	
executed an and al - transit	events resulting in death) Last Due to (or as a consequence or): d. VIUNDENDED 1tem#23a, PII, 27, 28a-1, perME, g860, 10/17/06 TT	
60, ate be execui	item#17, perFH, G860, 10/6/06 TT 23d. Date of delivery	
687 certific	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (Specify)	Year
P.O. Bo		
cords, law require has been si 2 should b	Hypertensive cardiovascular disease 1 Yes 2 No 3 Probable 24a. Was an autopsy performed? performed? death?	sy findings available pletion of cause of
Vital Rec ssician: The lis certificate director, page	h 25. Was case referred to medical 26. Place of Death (Check only one)	2 No
n of Vita	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other:	
ivision or Attendinater death Director: A:	Natural 5 Pending Pending Pending Prod 10/2/2006 Find 8:28 pm 1 Yes 2 No unknown	
Division ospital or Attending hours after death neral Director: After filled in by the function:		
Di To the Hospital owithin 24 hours a To the Funeral I completely filled	Sa. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started.	ause(s)
TI OF	29b. Signature and title of certifier 29c. License number O.C.M.E. October 4, 2006	Day, Year)
pend-	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat	e 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registra DHMH 17 Rev 1/200		

31589 3. Time of Death Year 2006 8:441 M

			For	S	State of N	1arylar	nd / Dep	artment of H	lealth and	Mental Hyg	giene U	06	3 5
		•	State Registrar				Ce	rtificate of l	Death	F	Reg. No.	_	
	Physicia /Medica	al	1. Decedent's Name (First, Mi Mayola Le 4a. Facility Name (If not institu	2 Mc	Intyr			4b. City, Town, or	Location of Dea	2. Date of Dea Month	Day	Year 2006	3. Time of
	Examine	er	Johns Hope		Hospita			Bal	Imore		10. 000,	NA	
	Funeral Director		5. Social Security Number 216 · 26 · 7114	6. Sex 1 ☐ M	7. A	ige (In yrs	last birthday)	Il Under 1 Year Months Days	If Under 24 Hr Hours Mir	(Month, Day	, Year) 1938	9. Birthi Cou	olace (State of
	Baryland	ctor	Usual Residence of Decedent 10a. State 10b. Cou	NA		10c. C	Balt	imone					10d. Inside Cit 1 X Yes
	th with the 23a or 28	al Director	10e. Street and Number 801 E. Pre	ston	stree	t		10f. Zip Code	1202		10g. Citizen of	What Cou	ntry?
036	urs a	by Funeral	11. Marilal Status 1 □ Never Married 2 ★ Nover	Married	Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	? (No	J.S. 13.	Was DecedenI of H II Yes, specify Cuba 1 ☐ Yes 2 X No	ispanic Origin? (In, Mexican, Pue Specify:	Specify Yes or No- into Rican, etc.)	14. Rad Bla Specif	ck, White,	can Indian, etc.
Baltimore, Maryland 21215-0036	within 72 ho ane. then *natur	Completed	15. Dece (Specify only hig Elementary/Secondary (0-1:		conpleted) College (1-40)		(Give	dent's Usual Occupi kind of work done of DO NOT use retired	during most of w d)	orking	16b. Kind of B		dustry
land 2	buld be filed with Mental Hygiene Brked other the atic event, the	To Be Co	17. Father's Name (First, Midd	SSIC	1 qui				18. Mother's Na	ame (First, Middle,	Maiden Surnan		
, Mary	and 2 should salth and Men n 27 ie marke er traumatic		19a. Informant's Name/Relation General McI	onship (Type, NTYPE)		1.Sbano		ng Address (Street a		L Baltin			
imore	2 a a a		20a. Method of Disposition 1 ⊠Burial 2 □ Crematic 4 □ Donation 5 □ Other		noval from Stat		Place of Dispo cemetery, cre RVVISOV		10.	Date 04.06	DWM4		
Balt	permit. Departm Importa any infu		21. Signature of Funeral Serv	ce Licensee	Su	W	Ž	2. Name and Address MUNN C. G HADS YOYK	ss of Facility Reene Fi 20ad Ba	uneral S Itimore M	enitos' D 2121	2	
			23a. Part1. Enter the disease shock, or heart failure.	or complicat	tions that caus cause on each	ed the dea line.	th. Do not en						Approximate Interval Bety Onset and D
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	CE C			vylv.	DETE	SNSE			
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	J 6	Due to (or a		quence of):	JE CH	CPIGNI	2 CO /AL	2116	HAF	

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death

1 Inpalient

28a. Date of Injury (Month, Day Year)

9☐ Unknown

4☐Pregnant at time ol death

Cause (Disease or injury that initiated events resulting in death) Last Exam Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ▼ No Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 ☐ Accident

9 Unknown

3 Suicide

4 Homicide

Certification: To Be

attending physician and for use as the burial-trans

been signed by the a within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s

Division of Vital Records, P.O. Box 68760,

o the Hospital or Attending Physicien: The law requires that the death certificate be execute

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier DINID Stomusag

31. Date filed (Month, Day, Year)

HABELLIDINGMIK

5 Pendina

investigation

0 5 2006

6 Could not be determined

mo

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

PHCA

3 Ectopic pregnancy

5 Other (specify)

29d. Date signed (Month, Day, Year) Oct 3, 2006

BALL MA LICUI

Location (Street and Number or Rural Route Number, City or Town, State)

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

1 Tyes

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

21X No

1 Yes 2 □ No

24a. Was an

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy performed? 1 ☐ Yes 2 No

28d. Describe how injury occurred

 Birthplace (State or Foreign Country) MD

> 10d. Inside City Limits 1 XYes 2 □ No

Approximate Interval Between Onset and Death

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

DHMH 17 Rev 1/2001

2 ER/Outpatient 3 DOA

28b. Time ol

28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

Patrick Nolan 06-06886 UNK UNK

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No. Registrar Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day Y September 12, 2006 1001 hrs **Medical Examiner** Patrick Nolan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death 1700 South Highland Avenue Baltimore 5. Social Security Number Un K6 Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Age (In yrs. last birthday) Funeral Months Days Director Country) June 27, 1945 1 X M Yrs Usual Residence of Decedent unk unk linside City Limits 10a. State unk 10b County 10c. City. Town or Location unk 28a-f show Yes 2 No , or items 23a or 28a-f shoremest be notified at once. Directo 10e Street and Number 10f. Zip Code 10g Citizen of What Country' unk unk USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? unk 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black unk White, etc. Never Married 2 Married Yes 2 No If Yes, Give Year 1 Yes 2 X No specify Divorced Specify: white 'natural'', þ 16a. Decedent's Usual Occupation (Give kind of work done ${
m unk}$ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) , MD 21215-0036 and 2 should be filed within 72 earth and Mental Hygiene permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than " other tranmatic event, the Medical unk unk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unk unk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ို 19a Informant's Name/Relationship (Type, Print) O.C.M.E. Penn Street Baltimore, MD 21201 Baltimore, I permit. Pages I and 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town State Date crematory or other place) Burial 2 Cremation 3 Removal from State 0.0 ner Specify: 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 21201 Name and Address of Facility ature of Funeral S irector 655 W. Baltimore Street cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Rart I Enter the disease, or complications failure. List only one cause on each line. Physician Between Onset and Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical X UNPENDED signed by the attending physician be detached for use as the burial -AMENDED item#23a,27,perME,g860, 10/11/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been uneral director, page 2 should 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes 25 Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be Hospital: 1 Other₄ Inpatient DOA Nursing Home 5 Residence 6 V Other Scene 1 🗸 Yes 2 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b Time of Injury 28d Describe how injury occurred Certification: 1 X Natural 5 Pending Yes 2 No 24 hours after death To the Funeral Director: Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City Could not be Suicide or Town State) determined Homicide 29a Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. September 13, 2006 30 Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31 Date filed (Month, Day, Year)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1 1 6 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER 23 **OBERFELDER** 2006 3:10 A M ELLEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 02/09/1929 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🔽 F MD 77 213-30-1593 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Examinations of the property of the property injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 3406 DEEP WILLOW AVENUE 21208 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (Ā) No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **EDUCATOR EDUCATION** 5± 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **GUNDERSHEIMER** STEIN HAROLD JEAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HUSBAND 3406 DEEP WILLOW AVENUE - BALTIMORE, MD 21208 WILLIAM OBERFELDER / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CEM. 10/4/2006 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) month Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical ending physic use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. To Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 1 ☐ Yes 2 ☐ No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) mpleted cause of death (Ite ii 27 a) (Type, Print) browles St. Bunc 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygien 2006 31592 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 300 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atons V) Year | If Under 24 Hrs Home Age (In yrs last birthday) timore **Funeral** 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours Min. 215-12-8512 1**⊠** M 2□ F Director Yrs Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural; or items 23a or 28a-f shoy ury or other traumatic avent, the Medical Examinan mantale melitied at 28a-f show 10d. Inside City Limits **Funeral Director** MD N BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1915 W. LAFAYETTE AVENUE 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ₩Widowed 4 □ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SPARROW POINT WORKER 121H GRADE NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be MATHEW POWELL MARIAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (DAUGHTER) PATRICIA STANTON 1317 CANTWELL RD. BALTO.

Date of Disposition (Name of MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or gonce. * 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 10.06.06 OWINGS MIUS, MD 21. Signa ve of Funeral Service License 22. Name and Address of Facility
VAUGHU C. GREENE FUNERAL SERVICE
5151 BAUTO. NATU PIKE, BAUTO. MO 21229 /ang/m 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MHEROSCLEROTIC Physician OFDID VASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infine diatacause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 5 Other (specify) Ö the be detached 9 Unknown 9 Unknown þ ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, IDNEY 1 🗌 Yes 2₽No 3 Probably 4 Unknown director, page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending s after death. investigation М 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) tha tha 29b. Signature and title of certifier 0 29c. License number 0 29d. Date signed (Month, Day, Year) erech 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTO MD 21201 14 ANI)
32. Registrar's Signature ASNEEM 31. Date filed (Month, Day, Year) 0 5 2006 Registrar

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		30 Name and address of person												-		- River
		Melissa Brassell, MD	Assistant M				enn Stre	eet, Ba	Itimore,	MD 2	21201		- .			
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 5 31595 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** stember 0210 AM Darylene Pratt 2006 /Medical 4a. Facility Name (If not institution, give street and number)

GOOD SAMAELLAN HOSPITAL 4c. County of Death 4b. City, Town, or Location of Death Examiner G000 BALtimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Sept 27, 1946 MO 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax 9. Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F 59 073-36-8279 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel; or Items 23s or 28s-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Item 27 is marked other than "naturel", or Items 23s or 28s-f show other treumstic event, the Middies Exeminar must be notified at MD 1√2 Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 E. Melrose Avenue 21212 Funeral USA 12. Was Decedent Ever in U. ank Amed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

1 ☐ Yes 2 ☒ No Specify: 14. Race - American Indian. unk Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Good Samaritan Hospital 5601 Loch Raven Blvd Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ☑Other (Specify) in state Signature of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows a rheart failure. List only one cause on each line.

Immediate cause (Final disease or condition resulting in death)

a. Metastance (arcinomas i) winking Prince (arcinomas ii) winking Prince (arcinomas iii) winking prince (a unn Approximate Interval Between Onset and Death Physician YEUN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant al time of death 5 ☐ Other (specify) as been signed by the a should be detached 9. Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an 1 Yes certificete To the Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ္ရ 1 🗌 Inpatient ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 TYes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the 29a. Certifier Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number September 26, 2006 Lich Pares Poulound Beltmore, Maryland dress of person who om leted cause of death (Item 23a) (Type, Print) 5201 Scauch sum 32. Registrar's Signature 31. Date filed (Month, Day, Year). Goarte 5 2006 State

Registrar

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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phillip J. Schwartz, M.D. 15225 Shady Grove Road Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature	>	ysicie s cert direct	0 B	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 🗆 DC	A Oth	or				6 □Other (Spe	cify)	
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D24398 October 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phillip J. Schwartz, M.D. 15225 Shady Grove Road Rockville, Maryland 20850 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		thin 24 thin 24 tha Fi	Medic	one)			nation and/or in				000011	a. mo mie,				
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					- 27	Registrar's Sign	nature	ENER!								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Year! 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** M DUTOBER 2006 RYALS 0 MARIA /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Randallstown

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Month, Day,

(Month, Day, Battimore Northwest Hospita 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 20F 219-80-9978 Yrs. 46 Sept Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ma Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? US 4 1109 21202 Webb 210 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 +n ustadian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hyals ၉ Thelma JOHNSON W. DOHN 19a, Informant's Name/Relationship Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mother Howard Park Ave 120 Balto. Thelma 3501 APT 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10/9/06 King Mem. WoodlawN 4 □Donation 5 Other (Specify) Cem. 21. Signature of Funeral Service Licenses Chartman-Harris Funeral Home 22. Name and Address of Facility 240 Reisterstown Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. ACQUIRED IMM Due to (or as a consequence of): IMMUNE DEFECIENCY /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? After this certificate funeral director, pag 1 Yes 2 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 \inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29d. Date signed (Month, Day Year) 29c. License number 29b. Signature and title of certifier MO october of D41410 200 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER MEHTA HOSPITAL CEI CENTER RUNDAUS TOWN MO MORTHWEST 31. Date filed (Month, Day, Year) State Registrar

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lelvin Dawron Richa I	rdson State of Maryland / Dep -For State Amend #10c Per FH G860 CE	artment of Health and Mer ଫ /f©∌/(®6f D ∄ath	Ital Hygiene Reg. No. 2006 3159
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) MELVIN D. RICHARDSON		2. Date of Death Month September 28, 2006 3. Time of Death 2052 hrs
	4a Facility Name (if not institution, give street and number) Sinai Hospital	4b. City, Town, or Location Baltimore	N/A
Director	5. Social Security Number 6. Sex 7. Age (In yrs. 216–90–5789 7. Age (In yrs. 35)	Months Days Hour	er 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
w any		, Town or Location Raltimore Randall	10d Inside City Limits 1 XXYes 2 No
tith the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 8802 Banner Road	10f. Zip Code 21133	10g. Citizen of What Country? USA
or items must be	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Year	J.S. 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical	n, Puerto Rican, etc.) White, etc.
5-0036 ed within 72 hours after tygiene other than "natural", the Medical Examiner Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give during most of working life. DO NO	kind of work done use retired) 16b. Kind of Business/Industry
Baltimore, MD 21215-0036 pernnt Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than "injury or other traumatic event, the Medical To Be Complet	12 17. Father's Name (First, Middle, Last) Melvin Richardson		House of Masters r's Name (First, Middle, Maiden Surname) ricia Lewis
MD 21 und 2 should I salth and Mer enn 27 is mar raumatic ev	19a. Informant's Name/Relationship (Type, Print) Patricia Lewis 20a. Method of Disposition 20b	N.	mber or Rural Route Number, City or Town, State, Zip Code) d, Randallstown, Md. 21133 Date 20c Location - City or Town, State
altimore, runt Pages I a spartment of He poortant: If ite	1XXBurial 2 Cremation 3 Removal from State	crematory or other place) odlawn Cemetery	10/06/2006 Baltimore, Md.
Physician	23a. Part I. Enter the disease, or complications that caused fiel deat	Estep Brothe 1300 Eutaw I	ers Funeral Service Place, Baltimore, Md. 21217 cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Asphyxia by hanging Due to (or as a consequence	of):	Death
Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury that imitated events resulting in death) Last b. Due to (or as a consequence of the consequen	100	
be execu sician and urial - tra	UNPENDED AMENDED		
Records, P.O. Box 68760. The law requires that the death certificate cate has been signed by the attending phyapage 2 should be detached for use as the completed by Physician/Me.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of prediction of the past 12 months? 1 Unknown	2 Fetal death 3 Ectop	23d. Date of delivery Month Day Year
Vital Records, P.O. I hysician: The law requires that the this certificate has been signed by the director, page 2 should be detached to Be Completed by Ph.	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in F	art I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available
	25. Was case referred to medical	26 Place of Death	autopsy performed? 1 ✓ Yes 2 No 1 (Check only one)
of Vital fing Physician After this certi funeral directo on: To Be	1 V Yes 2 No	P ER/Outpatient 3 DOA Other 4 28b. Time of Injury 28b. Injury at Wol	Nursing Home 5 Residence 6 Other. k? 28d. Describe how injury occurred
– ਵੜਾਨੀਨੀ	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 ✓ Suicide 6 Could not be 28a. Date of Injury Sep 28, 2006 28e. Place of Injury - At	2022 hrs 1 Yes 2 whome, farm, street, factory, office building, of	etc. 28f. Location (Street and Number or Rural Route Number, City
	4 Homicide determined (Specify) Townhou	dge, death occurred at the time, date and p	or Town, State) 3303 Paton Avenue, Baltimore, MD lace, and due to the cause(s) and manner as started. ccurred at the time, date and place, and due to the cause(s)
To the He within 24 To the Fi completel	29b Signature and title of certifier	29c. License numbe	
6	30. Name and address of person who completed cause of death (Ite Zabiullah Ali, M.D. Assistant Medical Examine	m 23a)	
State Registrar	31 Date filed (Month, Day, Year) 320 Registrar's Signal OCT 0.5 2006	ture	

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ı	Physici /Medic		Decedent's Name (First, Middle, La Eric Rogers	ast)					2. Date of D Month Sept.		Pay 2	Year	3. Time o	f Death
	Examin		4a. Facility Name (If not institution, gi		D: #4	и.	4b. City, Town, o	r Location of D	Baltimore	4	c. County	of Death	N/A	
	Funeral Director		5. Social Security Number 6. 216-66-8843	Pruid Park Lake Sex 7. Age 1 K Mg 2□ F	Unive - # 4 e (In yrs. last t		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of E	Birth Day, Yea		9. Birth Cou	place (State intry) Marylan	
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland	N/A	10c. City, To	wn or Lo		Baltimore			<u>.</u>		10d. Inside 0	City Limits
	h with the 23a or 28a	Funeral Director	10e. Street and Number 727 Druid Park Lake	Drive			10f. Zip Code	2121	17	10g. C	Citizen of		untry? S.A.	
200	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Iteme 23s or 28s-f show says injury or other traumatic event, I'm Madical Examinar Irusal to incillised at ODGs.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🗷 Øvorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 1 Yes, Give Year or Dates:			Was Decedent of F f Yes, specify Cubin 1 ☐ Yes 2 1 100	lispanic Origin an, Mexican, P Specify:	? (Specify Yes or Puerto Rican, etc.)	No-		ck, White	ican Indian, , etc. Black	
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7	within iene. then	dwo	Elementary/Secondary (0-12)	College (1-4or 5	i+)	IIFO. I	DO NOT use retire Bar	ber / Stylis	st			Hai	r Care	
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Mai	d 2 shou th and M t7 is mar traumat		19a. Informant's Name/Relationship Bridget Phillips	(Type, Print)	15				or Rural Route Num			State, Z	ip Code)	
ָרָ בּי	Pages 1 an ent of Heal nt: If item 2 ry or other		20a. Method of Disposition 1		20b. Place cemel	of Dispo tery, crer	sition (Name of natory or other place	De)	Date 10/03/0	20c.	Location		Town, State	
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	Physician /Medical		23a. Part . Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused y one cause on each lin	ъ. /		er the mode of dyir	NOIVIEW A	venue Norfilk rdiac or respiratory	, VII'g arrest,	jinia Z.	3513	Approxima Interval Be Onset and	tween
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5	rificate be executed in physicien and as the burial-transit	ai Examiner	that initiated events resulting in death) Last	c. SCIEC Due to (or as	a consequenc		١٥							
	ificate g phys	edic		d. VI Y PC	rten	510	V							
.O. DO.	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and compisiely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnancy	<i>'</i>		-		ite of delin		Year
7,00	quires that n signed b uld be deta	þ	Part II. Other significant conditions	contributing to death b	ut not resulting	in the u	nderlying cause giv	ren in Part I.			o use con 2 🗆 No	_	the cause of	death? Unknown
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A 110	certific rector	Be	25. Was case referred to medical examiner?	Hospital:			. 3□ DOA O#	00	Death (Check only					
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	al or Atter s after dea al Director ed in by the	Certification:	3 Suicide 6 Could not determined		ury - At home, c. (Specify)	farm, str	eet, factory, office		28f. Location City or 7	(Street a		ber or Ru	ral Route Nur	nber,
	ne Hospit n 24 hour ne Funere	Medical (29a. Certifier t⊠ Certifying P (Check only one) 1 ☑ Certifying P □ Medical Exa	hysician: To the best miner: On the basis of and manner sta	examination a	ge, death and/or in	n occurred at the til vestigation, in my o	me, date and p pinion, death o	place, and due to the occurred at the time	e cause e, date a	(s) and m ind place,	anner as and due	stated. to the cause(s)
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	1/		30. Name and address of person who	completed cause of d	eath (Item 23a			200d	eto, MO	71	715	<u> </u>	UG	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 5 2	32. Registr	ar's Signature		wells?	e, 000	C, D, 7000	-1	<u> </u>			

State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death 2. Date of Death 3. Time of Death **Physician** Hildegard L. Ragonese September 2006 6:25 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Baltimore 5 Brett Court Apt. 103 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Jan. 13, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 KF 88 217 03 5545 Germany Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fehow ir than "nature!; or items 23a or 28a-1 eho the Medical Examinar must be notified at Baltimore Baltimore 1 ☐ Yes 2 No Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 5 Brett Court Apt. 103 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 21 No Specify: Specify: White <u>۾</u> 3 → Widowed 4 Divorced ie marked other than "nature!", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Health Care Nursing 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fraziska Wojtaczowski Johann Jaschke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charlotte Disney / Daughter 16 Bohn Court Baltimore, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland Meadowridge Mem. Park 10/6/2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign July of Funer Parvice Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequer Examiner The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Box 68760,42 resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ٥ cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy performed? Yes 20 No 1 Yes Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death Check only one) 2 No Other: 1 ☐ Yes 1 Inpatient 4 Nursing Home 5 Residence 6 □Other (Specify) 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Ceath 28b. Time of Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No М investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed, (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month) State 5 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g860 10-26-06 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician Louise Virginia Robey 6:00 P. M 2006 October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Hammonds Lane Baltimore Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of An (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 🖺 F 220 12 6427 80 1926 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Anne Arundel Baltimore Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö U.S. 21225 5512 Moore Street or Iteme 23a death Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White ģ 3 Nidowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \text{th} \end{array}$ College (1-4or 5+) Clerical Worker Commercial Credit other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other treumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ida Grimm Newman Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5512 Moore Street Baltimore, Maryland 21225 Robert Robey, Jr. son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal Irom State Glen Burnie, Maryland Glen Haven Mem. Park 10/5/2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign 1 of Funeral Service License 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Netastatic **Physician** /Medical Due to (or as a consequence ol) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physiclen: The law requires that the death certificate be executed use as the burial-transif Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. Il yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day ĝ Month Year 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records. 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate tuneral director, pag 1 ☐ Yes 2 0No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient Other: 200 No Medical Certification: To 1 🗌 Yes 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending death. М 1 TYes 2 TNo investigation in by the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 94 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (0/2/06

State Registrar

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31. Date liled (Month, Day, Year) OCT 05 2006

Jude

Munerea

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

woold Rovad 32. Registrar's Signature

ORIGINAL

28 48

Glen Purvie, MD 21061

State of Maryland / Department of Health and Mental Hygien 206 For State Registrar 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year ŧ. Robinson come September 30, 2006 10:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Baltimore N/A Hospital Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 219 · 26 · 8785 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow the Medical Examiner must be notified at Baitimore Baltimore 1 ☐ Yes 2 📉 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Copperbend 21209 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Black þ Specify Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry t of Health and Mental Hygiene. If item 27 to marked other than College (1-4or 5+) Elementary/Secondary (0-12) Laborer Market 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be Robinson Sachate 19a. Informant's Name/Belationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna D. Higging 20a. Method of Disposition Edgewood, MD 21040 Cousin 20b. Place of Disposition (Name of cemetery, crematory or other Date 20c. Location - City or Town, State permit. Pages 1
Depertment of H
Important: If ite
ony injury or ott 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signatur Funeral Service Licensee Funeral Sovices 19.121 s. Stricker Street Balto. MD 21223 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia 10 days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 TYes 2 TNo Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 20 No 1 Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide pelli within 24 hours a To the Funerat [Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe September 30, 2006 ar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suzan Sinai Hospital of Baltimore Fattol 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 5 2006 0 Registrar

Robinson

Patient Known

Division of Vital Records, P.O. Box 68760,

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23s or 28s-f show any injury or other traumatic event, in a Modical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name (First, Middle Doucus Rot	,					2. Date of D Month SEPTEN		ay	Yeer	3. Time of Dear
	4a. Fecility Name (If not institution BALTING RG - WASH	n, give street and numb		17CB	4b. City, Town, o	r Location of Deat		4	c. County	of Death	
	5. Social Security Number 216-30-8300		Age (In yrs. i		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of 8 (Month, D	irth ay, Yea	ır)	-	place (State or For intry) MD
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ľ	17. Father's Name (First, Middle,	Last)				18. Mother's Nar	ne (First, Middle	e, Maide	en Sumam	10)	
١	George Albert	Roth, Sr.				Lavinia	Isabel	Ake	hurs	t	
-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Street	and Number or Ri	iral Route Numb	er, City	or Town,	State, Zi	ip Code)
	Mrs. Eileen P.	Willis /da		-	2 Shipley	Avenue	Particular Communication Commu	-			
İ	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 □Removal from St		lace of Dispo emetery, crei	osition (Name of matory or other place	· I	Date			•	own, State
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	21. Signature of Funeral Service	Licensee	Jus		2. Name and Addre	ss of Facility S Ave SW;					and the second second
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	23a. Part 1. Enter the disease, or shock, or hear filure. List Immediate Cause (Final		used the death th line.	a. Do not ent	ter the mode of dyin						Approximate Interval Between Onset and Deat
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Registrar

31604 State of Maryland / Department of Health and Mental Hygier 0 0 6

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۲,			Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic	1		MAE DARLE	NE RI				OCT.	2, 2	006	9:57 A M
	Examin	er	4a. Facility Name (If not institution, give st			4b. City		Location of Death			ounty of Death	
100	·	000	3419 LITTLESTOW 5. Social Security Number 6. Sex		yrs. last birtl		r 1 Year	IMINSTE	8. Date of Bir	th	ARROLL 9. Birthp	place (State or Foreign
	Funeral Director		220-28-8699 1 Usual Residence of Decedent	M 2X1F		rs. Months	Days	Hours Min.	3/26/	y, Year) 1932	MAR	YLAND
	ow oth	Ì	10a. State 10b. County	10	c. City, Town	or Location					1	0d. Inside City Limits
	Man B-f eh	tor	MD CARROL	L	WEST	MINSTE	R					1 □Yes 2X No
	death with the Maryland ms 23s or 28s-f ehow rmust be notified at	Director	10e. Street and Number			10f. Zi	p Code			10g. Citize	n of What Cour	ntry?
	s 23s	ral	3419 LITTLESTO		i= 11 C	12 Mar Dan	211		positiv Vac or No	14	USA Race - Americ	an Indian
030	be filed within 72 hours after death with the Marylan ital Hygiene id other than "natural", or fisms 23s or 28s-1 show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	 Was Decedent Evel Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 	III U.S.	If Yes, spe		spanic Origin? (S) n, Mexican, Puerto Specify:	o Rican, etc.)		Black, White,	etc.
3-003p	72 ho	eted	15. Decedent's Educ	ation completed)	16a.	Decedent's Usi (Give kind of w	ual Occupa	ation during most of wor	king	16b. Kind	of Business/In	dustry
N	ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	use retired	& COOK		REST	AURANT	1
7	filed within Hygiene. Ither then "	e Co	1 1 17. Father's Name (First, Middle, Last)		1	11111111	ODIC	18. Mother's Nan				
yland	ld be ental ked o	To Be		NK D. Mck	CINNEY	, SR.		PAULI	NE MAR	IE S	TOVER	
_	s 1 and 2 should be f Health and Mental ftem 27 is marked other trsumatic ev		19a. Informant's Name/Relationship (Typ	e, Print) SON	19b.	Mailing Addres	s (Street a	and Number or Ru	ral Route Numb	er, City or T	own, State, Zip	Code)
, Ma	5 # 7 5		DOUGLAS S. RICHA					h ST.,				1701
ore	Pages 1 and the properties of		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	HIOVALI HUIH State		Disposition (Na v, crematory or		ı	Date		tion - City or To	
Baitimor	it. Pa rtmen rtant: njury		4 Donation 5 Other (Specify) 21. Sgnutspace Final Service License		EADOW	BRANC:	H CE	M. 10/6 ss of Facility FI	706	WEST	MINSTE	R MD
n n	permit. Pages Department of I Important: If It eny injury or o		The state of the s	•				IN ST.,				
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.O. BOX	ath cer attendir for use	Physician/M	IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 2 No 9 ☐ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 □Ectopic 5 □ Other (s				23	d. Date of delive Month	ery Day Year
7	nrequires that the de been signed by the s should be detached	þ	Part II. Other significant conditions conf	tributing to death but n	ot resulting in	the underlying	cause givi	en in Part I.	£			he cause of death?
coras,	requir	eted								Yes 2□		oably 4 □Unknown
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VII a	Physicism: r this certificated fral director,	Be o	25. Was case referred to medical examiner?	ospital:			Oth	26. Place of Dea				
o	Phy rthis rald	To To	Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Out		28c. Injun Worl	4 Nuising n	ome 5 X Resi 28d. Describe			у)
0	nding lath. r: After e funer	atloi	Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ea <i>r)</i> Ir	njury M		K? Yes 2 □ No				
DIVISION	To the Hospitsi or Attending within 24 hours after death. To the Funersi Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, fai Specify)	rm, street, facto	ry, office			Street and wn, State)	Number or Rura	al Route Number,
	ne Hospítsi n 24 hours a ne Funersi l bletely filled	Medical		ician: To the best of mer: On the basis of exand manner stated	amination and							
	To the within 2 To the complet	Σ	29b. Signature and title of certifiet	\sim			9c. Licens				signed (Month,	
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		•	Stata	Maryland / Department of Heal Certificate of Dea			711116	31605
			Ragistrar Decedent's Name (First, Middle, Last)	Certificate of Dea		Reg. No		3. Time of Death
	Physici /Medic		Caverne Vernic	Le Spencer	0	Month Da	300C	8:45 \$
	Examin		a. Facility Name (If not institution, give street and number	0 11	90	40	County of Death	
	Funeral			Age (In vrs. last birthday) If Under 1 Year 11 U	Inder 24 Hrs. 8.	Date of Birth (Month, Day, Year	9. Birthp	place (State or Foreign
	Director		218-60-5974 10M 201F	52 Yrs. Months Days Ho	ours Min.	eb 24, 1	954 Cour	Md
	land ow		Jsual Residence of Decedent Oa. State 10b. County	10c. City, Town or Location			1	Od. Inside City Limits
	ith the Marylar or 28a-f ehow	ctor	Ma N/A	Baltimore				1 Yes 2 No
	with th	Director	0e. Street and Number	10f. Zip Code			itizen of What Cour	itry?
_	death with the Maryland ims 23a or 28a-f ehow	Funeral	918 & Biddle St. 1. Marital Status 12. Was Decede	ent Ever in U.S. 13. Was Decedent of Hispanies? If Yes, specify Cuban, Me	ic Origin? (Specif		5A 14. Race - Americ	
2 00	ours after death with the Maryla el', or Items 23a or 28a-f ehov Examiner must be multiled at		Armed Force 1 Never Married 2 Married 1 Yes 2 If Yes, Give	No 1 ☐ Yes 2 No Spi	exican, Puerto Ric necify:	an, etc.)	Black, White,	etc.
2-0036	72 hours after dea "natural", or items	ed by	3 Widowed 4 Divorced Year or Date	es: \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	-	16b. I	Kind of Business/Inc	dustry
N S	within 72 ene. then "ne	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	(Give kind of work done during life. DO NOT use retired)	g most of working		Himora	- City
12	filed wi Hygien other th	Con	12+-	Security Mo	Mother's Name (F	irst, Middle, Maide	ASING A	whority
772 rylanc	d be fi	To Be	John (zwi 5	. 10.7	Ella N	Suce Ne	. Hinto	\sim
Kalkmu Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nu eny injury or other treumatic event, the Mauli once.	ř	19a. Informant's Name/Relationship (Type, Rrint)	19b. Mailing Address (Street and N	Number or Rural R			Code)
2, Z Z X	l and 2 lealth om 27 her tre		Ellen Hinton 1313		rest Date	rack Ave	Balling ocation - City or To	Jr. 112120
8 p	ages ent of H it: if ite y or ot		to a method of disposition ↑ Burial 2 □ Cremation 3 □ Removal from Sta 4 □ Donation 5 □ Other (Specify)		10/2/		nsdo wn	
altir	mit. P partme portan / Injur.		21. Signature of Freeral Service Licensee	Mt 2ion Cemente (4) 22. Name and Address of 1	Facility Cho	Hman-	7.1	ineral Home
ä	Depa Impo eny is		Jeruf danny	5240 Paiste	cokwi		altimore	Md 21215
			23a. Part . Enter the disease, or complications that cau shock or heart failure. List only one cause on each	used the death. Do not enter the mode of dying, such line.	ch as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or	r as a consequence of);				iveelig
	Examiner			Hepatic failure				year.
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8760,	ate be executed physicien and the burial-transit	dical	d					
× 68	ertifica ling ph e as th	Med	IF FEMALE:					
Box 6	attend for us	Physician/Me	in the past 12 months?	th 2 Fetal death 3 Ectopic pregnancy nt at time of death 5 Other (specify)			23d. Date of delive Month	ery Day Year
0	t the d by the ached	hysi	1 Yes 2 No 4 Pregnan 9 Unknown 9 Unknown					
<u>8</u>	es tha igned be del	۵	Part II. Other significant conditions contributing to deat	th but not resulting in the underlying cause given in	Part I.		use contribute to the	
ord	requir	eted				1 ☐ Yes 2		3
Division of Vital Records, P.O.	he law e hes t	Completed				24a. Was an autopsy performed?	death?	opsy findings available impletion of cause of
ital	ien: T	BeC	25. Was case referred to medical	26.	Place of Death (0	1□ Yes 2⁄⊡N Check only one)	o 1 ☐ Yes	ZIZINO
)	hysic this ce	2	7			5 Residence		y)
o uo	ding P h. After I funera	tlon:	a partial Surelium	Injury 28b. Time of 28c. Injury at Work? Injury M 1 □ Yes		d. Describe how inj	ury occurred	
Visi	Atten	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of	of Injury - At home, farm, street, factory, office		Location (Street a City or Town, Sta		al Route Number,
ρία	ital or rs afte rei Dir led in l			g, etc. (Specify)				
	Hospi 24 hou Fune stely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner	pest of my knowledge, death occurred at the time, da sis of examination and/or investigation, in my opinior ar stated	ate and place, and n, death occurred	due to the cause(at the time, date ar	s) and manner as s nd place, and due to	tated. o the cause(s)
	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as	Mec	29b. Signature and title of certifier	29c. License num			ate signed (Month,	
	0		thank &	bon, mil, FACO DS	57088	Oct	Tow 03,	2006
	7, 7		30. Name and address of person who completed cause	of death (Item 23a) (Type, Print) T. Paul Race #70/	Bentin	nou, mi) 2120.	2
	Sta	ate	31. Date filed (Month, Day, Year) 32. Reg	gistrar's Signature	3-77			\.
	Regist	rar	OCT 0 5 2006	and D. Speciel				

Jerome Owens Spedden, Sr.

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 31606

		I- For State Registrar	Ce	rtificate of	Death		F	Reg. No.	00 31000
Physicia	n/	1. Decedent's Name (First, Middle,La			C n o o	idon (2. Date of De Month	Day Year	3. Time of Death 0735 hrs
Medical Examin		Jerome 4a. Facility Name (if not institution, gi	Owens		4b. City, Town, o	den S		er 27, 2006	
W		Sinai Hospital	oc stroot and namber/		Baltimore	,			
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Yea				9. Birthplace (State or oreign
Director	ı	214-26-5758	M 2 F 75	Yrs	Months Day	ys Hours	Min. 04	01 31	Country) MD
'n		Usual Residence of Decedent 10a. State 10b. County	Inc. Cit.	y, Town or Locat	ion	•	·		10d. Inside City Limits
Maryland 28a-f show any 1 at once.		MD NA		altimo:					1 X Yes 2 No
ryland a-f sh	턍	10e. Street and Number			10f. Zip Code		T. T. T.	10g. Citizen of What	
ith the Maryland 23a or 28a-f sho	인	4812 Park Heig	hts Ave			L215		U.S.	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once		11. Marital Status	12. Was Decedent Ever in I		s Decedent of H	ispanic Origin	n? (Specify Yes or N	lo- 14. Race	American Indian, Black,
death	Funeral	1 Never Married 2 Marrie	1 Yes 2 V No				Puerto Rican, etc.)	White,	
s after ral",	à	3 Widowed 4 Divorce 15. Decedent's Education (Specify of	d If Yes, Give Year		Yes 2 X N		and of works down	Specify: 16b. Kind of Busin	Black
2 hour "natu	ted	Elementary/Secondary (0-12)	College (1-4 or 5+)		it's Usual Occupa ost of working life			TOD. KING OF BUSIN	ness/industry
21215-0036 uld be filed within 72 hours af Mental Hygiene. marked other than "natural e event, the Medical Examin	Completed	Ünk	N/A	Tr	uck Dr:	iver		Various	s Company
5-0036 iled within 7 Hygiene. I other than the Medica		17. Father's Name (First, Middle, Las	t)			18. Mother's	Name (First, Middle	, Maiden Surname)	
121 Id be fin Mental narked event,	o Be	James G. Spedo	len	40h Mailin	a Address (Otto		phia Lan	e umber, City or Town,	State 7:0 Code)
MD 2121 d 2 should be f lth and Mental n 27 is marked numatic event,	۲	Brenda Johnson							
		20a. Method of Disposition	20b	. Place of Dispos	sition (Name of co	emetery,	Date	20c. Location - C	City or Town, State
Baltimore, MD 2 bernit. Pages I and 2 shou Department of Health and I Important: If item 27 is n injury or other traumatic		1 X Burial 2 Cremation 3 4 Donation 5 Other Specif	•	crematory or of			10/4/06	Baltime	ore, Md
Baltimo permit. Page Department Important: injury or otl		21. Signature of Funeral Service Lice			lame and Addres				
		Dhy 5.9	Lete	143	00_Waba	ash A	ve, Balt	imore, !	Md 21215
Physician /Medical		23a Part I. Enter the disease, or com failure. Us only one cause on e	each line.				rdiac or respiratory a	rrest, shock, or hear	t Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Hypertensive Atheroso		iovascular D	isease			Death
		Sequentially list conditions,),						
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	of):					
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):					
760, icate be executed physician and the burial - transit			l,						
760, icate be e: physiciar the burial	Medical	UNPENDED	AMENDED					23d. Date of d	elivery
18760 rifficate b ing physical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre		etal death 3	Ectopic	pregnancy	Month Month	Day Year
Box 68' death certiff he attending d for use as	Physician	1 Yes 2 No 9 Unknow	4 Pregnant at time of o	death 5 0	ther (Specify)				
he de	Phy	Part II. Other significant conditions	9 Ulkilowii	resulting in the	underlying cause	given in Parl	t I. 23e. Did	tobacco use contrib	ute to the cause of death?
P.O ires that t signed by	ò		Ü					es 2 No 3	Probably 4 🗸 Unknown
ords, w require s been si should t	Completed	1					24a. Wa		ere autopsy findings available or to completion of cause of
of Vital Records, og Physician: The law requir Witer this certificate has been someral director, page 2 should!	d m						per		eath?
tal Re(inn: The certificate		25. Was case referred to medical			26.Plac	ce of Death (0	Check only one)	, 20, 10	100 2 100
Vital I hysician: this certifi I director,	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	✓ ER/Outpatien	t 3 DOA	Other ₄	Nursing Home 5	Residence 6	Other:
ion of tending Plueath. tor: After the funeral	T:T	27. Manner of Death 1 ✓ Natural 5 Deading	28a. Date of Injury (Month, Day,Year)	28b. Time of		jury at Work?		e how injury occurred	d
Sior Attend death sctor:	catic	2 Accident 5 Pending Investiga	tion Discount Indiana At	hama form star		Yes 2 I		(Street and Number	or Rural Route Number, City
Division pital or Attendi ours after death. eral Director: /	Certification:	3 Suicide 6 Could no determin		nome, ram, sire	et, factory, office	bullaling, etc	or Town		of Rural Route Number, City
Hospi 24 hour Funer tely fil		Offic Continue	cian: To the best of my knowle	edge, death occu	rred at the time,	date and plac	ce, and due to the ca	use(s) and manner a	as started.
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Medical	one) 2 Medical Examin	er: On the basis of examination and manner stated.	and/or investiga	tion, in my opinio	on, death occ	urred at the time, dat	te and place, and du	e to the cause(s)
	ž	29b. Signature and title of certifier				nse number			(Month, Day, Year)
^		my m,	mid		0.0	C.M.E.		September 2	20, 2000
1		30. Name and address of person who Ling Li, MD Assistant		·	et, Baltimore	, MD 2120	01		
	ate		32 Registrar's Signa		Ma A				
Regis		007 0 5 20	ns the man of	The Asset of	The state of the s				

Type of the management and the complete the
State of Maryland / Department of Health and Mental Hygien 2006

		For State Registrar	State of Marylar	nd / Dep	artme		ealth and	Mental H	ygiene Reg. No	2006	5 3	1607
Physiciar /Medica Examinei		Decedent's Name (First, Middle, Last) Frederick Lowis 4a. Facility Name (If not institution, give s	Schuler, Jr.	•	4b. City	, Town, or	Location of Deat	2. Date of D Month O 9 -	Da		ar 10	ime of Death
Funeral Director		 Social Security Number 6. Sex 	opital Center 7. Age (In yrs. 1 77	last birthday) Yrs.		Sed er 1 Year Days	If Under 24 Hrs Hours Min.	(Month, D	av. Year)	9.	MOTE Birthplace (S Country) MATYLA	State or Foreign
DESIGNOTE, INSTITUTE 2 12.13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Exemplation must be notified at 2002.	פכנסו	10a. State 10b. County Maryland Baltimore 10e. Street and Number		ty, Town or Lo	В	altim	ore		10g. Cit	tizen of Wha	10	side City Limits Yes 2 No
th with	2	2239 Firethorn Ro	ad			21	220			u.s	.A.	
of within 72 hours after death with the Margiene. er then "natural", or iteme 23a or 28a-fs the Medical Examinar must be notified.	5	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 ☐ Yes		spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or N to Rican, etc.)	10-		American Ind White, etc.	
ed within 72 hor ygiene. ner then "natura it, the Medical E	nubicien.	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Dece (Give life. Manac			ntion furing most of wo	rking	Soc	ind of Busine Lial Scrinist	ecurit	
buld be filed Mental Hygi arked other atic event,	ט	17. Father's Name (First, Middle, Last) Frederick Louis	Schuler, Sr.		Janen		18. Mother's Nai			Sumame)		
nd 2 sho lith and 1 27 is mu		19a. Informant's Name/Relationship (Type Marie M. Schuler	oe, Print) (Wife)	4	-		und Number or Ri LN Rd., 1					
Permit. Pages 1 and 2 should be fitted. Department of Health and Mental Hymportant: if item 27 is marked oth any injury or other traumatic eventance.		20a. Method of Disposition 1 □X Burial 2 □ Commation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	Place of Disponentery, cre-	osition (Na matory or	ame of other place	9)	Date 7/2006	20c. L	ocation - City	or Town, St	
permit. Departminents imports sny inju		21. Signature of Funeral Service Licenses		2:	2. Name a	and Addres	s of Facility So	chimunek	Fun	eral t	lomes	greetita
Physician /Medical Examiner e private transit Physician and private transit Physician and private transit Physician and private transit Physician and private transit Physician and private transit Physician and private transit and private transit are private transit and private tr	FValling	23 NPart I Enter the disease, or or implication of the control of	Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect	quence of):	far the mo		g, such as cardia	c or respiratory	arrest,		Interv	oximate all Between t and Death
The taw requires that the death certificate site has been signed by the attending physicage 2 should be detached for use as the completed by Physician/Medica		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Sc. If yes, outcome of pregn. 1 Live birth 2 Fete 4 Pregnant at time of c	Il death 3	⊒Ectopic p ⊒ Other (s					23d. Date of Month	delivery Day	Year
w requires that is been signed be should be detailed by Please and the please are should be detailed by Please are should be pleased are should be please are should be please are should be pleased are should be pleased are should be pleased are should be pleased are should be pleased are should be pleased are should be pleased are should be pleased are should be pleased are should be pleased are should be pleased are should be pleased are should	5	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	ınderlying	cause give	n in Part I.		tobacco	use contribut	e to the caus	se of death?
Physicien: The law requires I this certificate has been signeral director, page 2 should be to TO Be Commissed by					·			24a. Wa auto perl 1 ☐ Yes	opsy formed?/	deat	h?	dings available on of cause of
certificate	3	25. Was case referred to medical examiner?	ospital:			Othe	26. Place of Dea	ath (Check only	one)			
D 55 C		27. Mannet of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury Work	4 Nursing F	lome 5 Res 28d. Describe			Specify)	
To the Hospitel or Attending Physicien: The within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com		2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, sti				28f. Location City or To	(Street ar own, State	nd Number o	r Rural Route	a Number,
he Hospi in 24 hour he Funer pletely fill		29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my knower: On the pasis of examina	wledge, deat ition and/or in	h accurred	d at the tim n, in my op	e, date and place inion, death occi	a, and due to the urred at the time	e cause(s) and manne d place, and	r as stated. due to the ca	ause(s)
To the To the comple	=	29b. Signature and title of certifier	and manyler stated.			9c. License				ite signed (M	. , .	(ear)
141		30. Name and address of person who cou	mpleted cause of death (Iter	n 23a) (Type.	Print)	100	Drive &	Ba. Himi	16	Ud 2)	00	
State Registrar		31. Date filed (Month, Day, Year) OCT 0 5 200	32 Pegistrar's Signa	ature	oak?	J		- 0- 1 11 1110	/	110 401	~ ~ /	

			A1 : 1 1/2 MD /	State of M	aryland /	Depar	tment of t ificate of	Health and N			16	31608		
			Amend item#2, perMD, (1. Decedant's Name (First, Middla, L		11	Certi	ncate or	Dealli	2. Data of De	Reg. No. eth 10/4/20	776	3. Time of Death		
н	Physicia /Medic		Balbir S.	Sende	V ,				Month	-0-5-7-24	Year	610am		
	Examin													
1_			321 Lord Byro					Cockeys			ltimo	ore		
	Funeral			Sax 7. Ag	ga (In yrs. last i		If Undar 1 Yaar Months Days		(Month, De	h y, Yee <i>r)</i>	9. Birthpl Coun	aca (Stata or Foraign try)		
	Director		214-23-2079 Usual Residence of Decedant	X	55	113.			MAR 5	, 195	l Inc	lia		
	how #		10a. Steta 10b. County		10c. City, To	wn or Loca	tion				10	Od. Inside City Limits		
	Ba-1 s	cto	Baltimore Cockeysville								1 □ Yas 2 □ No			
	with the Meryland or 28a-f show the notified at	Funeral Director	10e. Street and Number				10f. Zip Coda			10g. Citizen of	What Coun	ry?		
	s eftar daath w or items 23a aminer mant	eral	321 Lord Byron	1 Lane, A			2103			India				
10	ftar d	Fun	11. Marital Status 1 □ Navar Marriad 2 Married	Armed Foreses	, , , , , , , , , , , , , , , , , , , ,	IS. Wa	as, specify Cub	Hispanic Origin? (Sp an, Maxican, Puarto	Rican, etc.)	Blace	ce - Amarica ck, White, e			
21215-0036	within 72 hours eftar daath with tha Meryland ena. than "natural", or items 23e or 28e-f show its Medical Examiner mant be institled at	Ď	3 ☐ Widowad 4 ☐ Divorced	d 1 Yes 2 Mo If Yes, Giva Yeer or Datas:		1 ☐ Yes 2 💢 No Specify:				Specify	Asia	n Indian		
5-0	s 1 and 2 should be filad within 72 hours if Haalth and Mental Hygiena. Item 27 is marked other than "natural", other traumatic event, the Medical Exa	eted	15. Decedant's E (Spacify only highast gi	ducetion ada completad)	16	a. Deceder	nt's Usual Occup	pation during most of work	rina	16b. Kind of B				
121	within	Completed	Elamantary/Secondary (0-12)	Collega (1-4or	5+) T			during most of work d)		3T / A				
	filad with Hygiena. Ither than		17. Fathar's Name (First, Middla, Las	t)	D	isab]	Leu	18. Mothar's Nam	e (First Middla	N/A	nal			
an	should be filad withind Mental Hygiena. merked other than imatic event, the Mental Hygiena.	To Be	Balwant Sehder					Surjit						
Maryland	2 should and Men is marked aumatic		19a. Informant's Name/Ralationship	(Type, Print)	15	b. Mailing	Address (Street	and Numbar or Rur		r, City or Town,	Stata, Zip	Parts) 21 020		
	1 and 2 Haalth 3 em 27 is		Amarjit Sehder	/Wife		321 I	Lord B							
ore	6 O _ L	23	Amarjit Sehdev/Wife 321 Lord Byron Lane, Apt 101 Cockeysville, 20a. Method of Disposition 1 Burial 2 Kremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata											
Baltimore,	parmit. Peg Dapartment Important: If any injury o	16	4 ☐ Donation 5 ☐ Other (Speci	fy)	Metro	-	natory,I		10/5/06	Baltimo	re, M	D		
Ba	parmit. Pe Dapartmer important: any injury once.		21. Signature of Funaral Sarvice Lice	C. Todd	Dring		ame and Addra	iss of Facility Ineral Hon	ne. P.A.					
	- III		301 Frederick Rd Catonsville, MD 21228											
Æ	Physician		shock, or haart failure. List only	one cause on aach li	ne.	not antar i	na mode or dyir	ng, such as cardiac	or raspiratory ar	rest,	- 1	Approximate Interval Between Onsat and Death		
	/Medical		Immediate Cause (Final	My	cand	n'al	Infan	chon			i	minutes		
	Examiner		disaase or condition rasulting in death)	a	Due to (or as a	a conseque	nce of):				1			
	8 H 5	ine		n Dia	setes	Me	Infernoe of):	type 2	·		į	10 years		
	ificeta be axecuted g physician end as tha bunal-transit	Examiner	Sequantially list conditions, Due to (or as a consequence of):											
68760,	a be a	edicai	rial initiated availts											
68									1044					
Box	The lew requires that the death cardificate hes been signed by the attanding page 2 should be deteched for use as	an/	a. Systemic Hypertensian 10 year									10 years		
0	tha at had fo	ysic	Part II. Other significant conditions	23b. Did to	23b. Did tobacco use contribute to the cause of death?									
P.O.	that the da										3 🗌 Probe	ably 4 Unknown		
rds	w requires that s bean signed i should be dat	0							24a. Was a	n autopsv	24b. War	a autopsy findings		
Ö	w req	Sete							parfor	med?	avai	labla prior to pletion of causa seth?		
A.	Tha lew eta hes paga 2	Completed by							10Y	es 22No		Yes 2□No		
ital			25. Was cese rafarred to madical examinar?	25. Was cese ratarred to madical 26. Place of Death (Check only one)										
<u>}</u>		2	1 ☐ Yas 2 No	Hospital: 1 ☐ Inpatia	nt 2□ER/O	utpatient		4 Li Nursing Ho	-					
Division of Vital Records,	Ilng P.	Certification:	27. Manner of Death 1 ☑ Naturel 5 ☐ Panding	28a. Date of Inju (Month, De)	(Year)	Time of Injury	28c. Injur		28d. Describe h		ad			
isi	Attending Far daath. ector: After by the funar	Ica	2 Accidant investigatio 3 Suicida 6 Could not b			(1)		Yas 2□No		on (Street and Number or Rural Route Number,				
S	aftar aftar dinb	e l	4 Homicida datarmined 28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify)					City or Town, Stata)						
			29a. Certifier (Check only Check only 20 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the tima, date and place, and due to the ceuse(s) and mannar es steted.											
	the H in 24 the Fi	redical	(176)	niner: On the basis of and manner sta	ted.	ndvor inväst								
	So T Will	Σ	250. Sala signed (World, I									-		
•	; <		D0059917 10/04/2006									>		
30. Nama and addrass of person who completed cause of death (Item 23a) (Typa, Print) Kylwant Singh M 2000 W. Baltimore Street, Baltimore MD 213									10D1					
	State	9	31. Data filad (Month, Day, Year)	32 Ragistre	r's Signature			7- 1-10	Manual 1 offices	3				
	Registra	_	OCT 0 5 200	6 Region	. H.	Coast	20							
DHM	IH 16 Rev 6/95			1-03-00		ORIG	INAL							

			For State Registrer	State of Ma	ryland / Depa <i>Cei</i>	artment of H			gienez ()	06 31609
	Physici		1. Decedent's Name (First, Middle, Last)	tinahi	emb Sr.			2. Date of De Month	Day	Year 12'30 A M
	/Medic Examin		4a. Facility Name (If not institution, give s LINI VENSITY OF Marylo	street and number)		4b. City, Town, or	Location of Dear		4c. County	
	Funeral Director		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th	9. Birthplace (State or Foreign Country) Maryland
	D.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Maryl	ctor	Maryland N/A		Balti	more				1 ∯Yes 2 □ No
	3a or 28	i Dire	10e. Street and Number 1417 West Ostend S	St.		10f. Zip Code 21223			10g. Citizen of V USA	What Country?
920	ges 1 end 2 should be filed within 72 hours after death with the Maryland it of Health and Mentel Hygiene. If item 27 is marked other than "naturel", or Items 23s or 28s-f show or other traumatic event, the Medical Examinatment be multilad at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates:	lo	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (\$ n, Mexican, Puer Specify:	Specify Yes or No rto Rican, etc.)		e - American Indian, ck, White, etc. v: White
21215-0036	within 72 ho ane. than "natur	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0·12)	cation e completed) College (1-4or 5	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wo	orking	16b. Kind of Bu	usiness/Industry
	permit. Pages 1 end 2 should be filed within Depertment of Health and Mentel Hygiene. Importants: If item 27 is marked other than any follury or other traumatic event, II and once.	To Be Co	17. Father's Name (First, Middle, Last) Herbert Stinchco	omb	N/A	—(Disabl	18. Mother's Na	me (First, Middle V. Brys		A
Maryland	end 2 shou Balth and M n 27 is mai		19a. Informant's Name/Relationship (Ty. Virginia Marlene	pe, Print) e Stinchco	omb, wife	ng Address (Street a	and Number of R stend St	ura/Route Numb Baltir	er. City or Town. Nore, MD	State, Zip Code) 21223
Baltimore,	Pages 1 enent of Heinant: If Item		20a. Mathod of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dispo cemetery, cres Cedar Hil	natory or other plac	y 10-	Date -05-06		City or Town, State urnie, MD
Balti	permit. Depertriting any laje.		21. Signature of Femeral Service License	Home of 1	ansdown	e. MD. 21227				
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final	cations that caused ne cause on each lin	the death. Do not ent e.	er the mode of dying	g, such as cardia	c of respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resutting in death)	Due to (or as a	a consequence of):	71 00 00	~ ~ ~ ~	250		
V	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence of):					
8760, <	icate be executed physicien and s the burial-transit	dicai Exa	resulting in death) Last		a consequence of):					
.O. Box 68	ath certific ittending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dai Mo	te of delivery nth Day Year
Δ.	quires that the de n signed by the a lid be detached f	<u>م</u>	Part II. Other significant conditions cor	ntributing to death bu	ut not resulting in the u	nderlying cause give	en in Part I.		obacco use cont Yes 2 □ No	nbute to the cause of death? 3 □ Probably 4 □ Unknown
of Vital Records,		Completed						24a. Was auto perfo 1 Yes	osy ormed?	Were autopsy findings available prior to completion of cause of death? I □ Yes 2 ☑ No
/ita	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			i ou		ath (Check only	one)	
on of √	ling Physician: After this certification in the second of	၉	1 ☐ Yes 2 No ☐ Parting 27. Manner of Death 1 Naturat 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time o	28c. Injun Work	/ at	Home 5 Resi	dence 6 Oth	
Division	To the Hospital or Attending Physician: within 24 hours effer death. To the Funerel Director: Affer this certific completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	iry - At home, farm, str c. (Specify)			28f. Location (City or To		er or Rural Route Number,
	To the Hospital within 24 hours etc the Funeral completely filled	Medicai C	29a. Certifier (Check only one) 1 Certifying Physical Exemination (Check only one)	sicien: To the best of ner: On the basis of and manner sta	of my knowledge, death examination and/or in ted.	h occurred at the tim vestigation, in my of	ne, date and plac pinion, death occ	e, and due to the curred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	2h		29c. License	854/	6	29d. Date signer	d (Month, Day, Year)
	H		30. Name and address of person who or Wendy Oaths	empleted cause of de	eath (Item 23a) (Type,	Print)	Baltin	nore. N	Parylas	and due to the cause(s) d (Month, Day, Year) er 1, 2006 d 21201
	Sta Regista		31. Date filed (Month, Day Year) 5	2006 ^{32. Registra}	ar's Signature	forth				

				For State Registrar	State of I	Maryland / Dep		Health and M		ene .	16	31610
		Dhyaia	:	1. Decedent's Name (First, Middle, Las	")	, -			2. Date of Death Month	Day	Year	3. Time of Death
_		Physic /Medi		Joseph Simon					September			2:15 PM M
		Exami	ner	4a. Facility Name (If not institution, give		er)		, or Location of Death		4c. County	of Death	
	*	Funcial	-	Joseph Richey Ho 5. Social Security Number 6. Se		Age (In yrs. last birthday		timore ar If Under 24 Hrs.	8 Date of Birth		0 Birth	place (State or Foreign
		Funeral Director			ZM 2□F	74 Yrs.	Months Day		8. Date of Birth (Month, Day, Ye Aug 15,	1932	Cou	York
		yland		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
		with the Maryland a or 28a-f ehow	ctor	MD		Baltim	ore					1x Yes 2□No
		or 28	Dire	10e. Street and Number			10f. Zip Code)	10g.	. Citizen of V	Vhat Cou	intry?
		e 23a	srai	19 N. Carrollton				21223			SA	
	"	fter d	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 X Yes 2	nt Ever in U.S. 13. is?	If Yes, specify Cu	f Hispanic Origin? (Sp Jban, Mexican, Puerto	Rican, etc.)		e - Amen k, White,	can Indian, , etc.
3	036	ours aft	by	3 ☐ Widowed 4 🎇 Divorced	1 XYes 2 [If Yes, Give Year or Date	s:	1 ☐ Yes 21 N	o Specify:		Specify	. b1a	ick
J:15pm	21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f ehow the Modical Examiner must be notified at	Completed by Funeral Director	15. Decedent's Ed (Specify only highest grad	ication le completed)	(Give	ident's Usual Occ	ne during most of work	sina 16t	b. Kind of Bu	ısiness/Ir	ndustry
	121	within	ldm	Elementary/Secondary (0-12)	College (1-4d	or 5+) /ife.	DO NOT use retii	red)				
0		e filed Il Hygie other vent, tr		12 17. Father's Name (First, Middle, Last)	0	tru	ıck drive		e (First, Middle, Mai	transp	orta	tion
	lan	lid be fental rked c	To Be	Joseph Simon Sr					a Barnes	<u>-</u>	-,	
0	Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 le marked other than other traumatic event, the H	Γ.	19a. Informant's Name/Relationship (7	(pe, Print)	19b. Mail	ing Address (Stree	et and Number or Rur		ity or Town,	State, Zip	o Code)
0		s 1 and 2 if Health a item 27 le other tree		David Simon/broth	er			ham Drive	Richmond,	VA 2	23222	2
1/27/06	altimore,	00-		20a. Method of Disposition 1 Burial 2 Cremation 3 D	Removal from Sta	18	osition (Name of matory or other pi		Date 200	. Location -	City or T	own, State
10	Ħ	보 문문을 .		4 □Donation 5 ½ ify. 21. Sig_ture _funeral Service U eng		7						
9	Ba	Depa Impo any ic		Ronalds	Vada,	rector Si	tate Ana A lti more	tomy Board MD 2120	655 W. B	altimo	re S	Street
		Physician	0)	23a. Part1. Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final disease or condition	()							Approximate Interval Between Onset and Death
•		/Medical Examiner		resulting in death)		as a consequence of):		1				(2) COLONITO
	뜟.	F .	-6	Equantially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consequence of):		4				
		uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
	o,	be executed ician and burial-transi		resulting in death) Last	Due to (or a	as a consequence of):						
	Box 68760,	ys e	lical		d							NG ST. Y
	9 x	leath certifica attending pt I for use as t	/Me	IF FEMALE:	3c. If yes, outcom	ne of pregnancy						
_	P.O. Bo	The law requires that the death certifica Ne has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1☐Live birth	2 Fetal death 3 at time of death 5	Ectopic pregnand Other (specify)	су		23d. Date Mor		ery Day Year
rimon		ires that signed b d be deta	by Pi	Part II. Other significant conditions co	ntributing to death	~ V	/ .	ivén in Part I.	23e. Did tobacc	co use contr	ibute to ti	he cause of death?
12	ord	v require been si should l	ted	Chronic Obst	MICHAE	rumona	ny dus	sease	1 Yes	2 🗆 No	3 Prob	pably 4 Unknown
()	Records,	e 2 sh	Completed	Hyr Eng	100	1			24a. Was an autopsy	24b. V	Vere auto	psy findings available mpletion of cause of
5		i ician: The lav certificate has rector, page 2		11					performed 1 ☐ Yes 2 ☐	₽ d	eath?	
R.P.	Vital	Attending Physician: r death. sctor: After this certific by the funeral director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	fospital:	Anna All EDIO Annahir		thos	h (Check only one)	.V		14000
8	10	g Phy er this eral d		27. Manner of Death	1 Inpa 28a. Date of In (Month, D		IL SLI DOA	4 LI Nursing Ho	me 5 TResidence 28d. Describe how in			n) Tishee
-1	ior	utending F death. ctor: After y the funera	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, L	Day Year) Injury		ork? ☐Yes 2☐No				8
	Division	al or Atters after de I Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of I building,	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office		28f. Location (Street City or Town, St	t and Numbe tate)	or Aura	I Route Number,
		To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)	sician: To the bes	st of my knowledge, death of examination and/or in stated.	n occurred at the t vestigation, in my	time, date and place, opinion, death occurr	and due to the cause red at the time, date a	e(s) and mar and place, a	nner as si	tated. o the cause(s)
		To the within 2 To the complet	Me	29b. Signature and little of certifier	1'-		29c. Licen	nse number		Date signed	(Mpnth,	Day, Year)
)			MA	A	MD	$\perp D$	125 12	- 0	19/27	120	106
				30. Name and address of person who co	mpleted cause of	death (Item 23a) (Type,	Print)	ll Roa	id #315	Bul	+ Mi	D 21210
		Sta Registr		31. Date filed (Month, Day, Year) OCT 0 5 2006	32. Regis	trar's Signature	w				1 . 4-	

			1 _ State		artment of Health and rtificate of Death		71115 3 5 1
П	207 2		1. Decedent's Name (First, Middle, Last)		incate of Death	2. Date of Death	3. Time of Death
	Physici /Medic		Kenneth Lee Stonebreaker			Sente was	Day Year 1253 M
5 5	Examir		4a. Facility Name (If not institution, give street and number)	,	4b. City, Town, or Location of Deat		4c. County ol Death
			Laurel Regional to	tospital	Laurel		Prince George's
	 ✓ Funeral ✓ Director 		5. Social Security Number 6. Sex 7. Age 1 № 1 1 № 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(In Yrs. last birthday) 55 Yrs.	Il Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Y	(ear) 9. Birthplace (State of Foreign Country) 1111 k
ъх.			Usual Residence of Decedent	33		Aug 14,	1951
	rylan	_	10a. State 10b. County unk	10c. City, Town or Lo			10d. Inside City Limits
	h the Maryland r 28a-f ahow	Director	VA	Kuck	ersville		1 ☐ Yes 2 No
	with the		10e. Street and Number		10f. Zip Code	10g	J. Citizen of What Country?
	death	Funerai	220 Shotwell Road 11. Marital Status unk 12. Was Decedent E	ver in U.S. 12 13. \	Vas Decedent of Hispanic Origin? (S	necify Yes or No-	USA 14. Race - American Indian,
215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itama 23e or 28e-1 show ha Madical Examinat intuit be invittled at	by	1 Never Married 2 Married 1 Yes 2 No. 3 Widowed 4 Divorced Year or Dates:	0	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer i □ Yes 2፟፟ No Specify:	o Rican, etc.)	Black, While, etc. Specify: White
2 2	72 hc	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of wo.	unk 16	b. Kind of Business/Industry unk
Z	within and the shape of the sha	Completed	Elementary/Secondary (0-12) College (1-4or 5- unk unk	life [DO NOT use retired)		
7	filled Hygi ther int,	o Co	17. Father's Name (First, Middle, Last)		unk 18. Mother's Nar	ne (First, Middle, Ma	iden Sumame) unk
iand	Aental Aental rked o	To Be				ing (i mai, maara, ma	dir.
2	s 1 and 2 should t if Health and Ment item 27 is marked other traumatic	_	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number or Ru	ıral Route Number, C	City or Town, State, Zip Code)
, Ma	12 a	١.	Laurel Regional Hospital		Van Dusen Road H	attsville	, MD 20707
saitimore	permit. Pages 1 al Department of Hea Important: If item any injury or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ₩ Other (Specify) in state		sition (Name of natory or other place)	Date 20	c. Location - City or Town, State
Dag	permit. Depart Import any inj		21. Signature of Funeral School Sicensee Dare	158	Name and Address of Facility ate Anatomy Boar 1timore, MD 212	JI	
			23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line	he death. Do not ente	er the mode of dying, such as cardiac	or respiratory arrest	Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Arterio	regerotic	Hypertensine	Heart.	Discase Onset and Death
	Examiner		Due to (or as a	consequence of):	, ,		
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a	consequence of):			
	cuted nd ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events				
Š	e exe ian al urial-t	EX	resulting in death) Last Due to (or as a	consequence of):			
9790	icate be executed physician and the burial-transit	dicai	d				
D X O	ding Ise as	/Me	IF FEMALE: 23c. If yes, outcome o	pregnancy			
0	w requires that the death certif been signed by the attending should be detached for use a	Physician/Me	in the past 12 months? 1 Ves 2 No 4 Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
)	by the	hys	9 ☐ Unknown 9 ☐ Unknown				
ń	igned be de	þ	Part II. Other significant conditions contributing to death but	not resulting in the un	derlying cause given in Part I.		cco use contribute to the cause of death?
cords,	requi	eted				1 🗆 Yes	2 No 3 Probably 4 Onknown
ם וב	ding Physician: The law requires that the death centif h. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Completed				24a. Was an autopsy performed	
Š	aician certif rector	o Be	25. Was case referred to medical examination Hospital:		Other	th (Check only one)	
5	Physic arthis aral di	\vdash	27. Manner of Death 28a. Date of Injury	28b. Time of	3 DOA 4 Nursing H	ome 5 Residence 28d. Describe how	e 6 Other (Specify)
5	nding ath. r: Afte e func	atio	1. ☐ Natural 5 ☐ Pending (Month, Day) 2 ☐ Accident investigation	Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After cimpletely filled in by the funer.	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injurbuilding, etc.	y - At home, farm, stre (Specify)	et, factory, office	28l. Location (Stree City or Town, S	nt and Number or Rural Route Number, Nate)
	ne Hospit 24 hours ne Funera sletely fille	edicai (29a. Certifier (Crack Sub) one) 1 Centifying Physician: To the best of a long physician and manner state and manner state.	xamination anwor invi	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To th	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
			Savador Shester	Do	HO055927	5-0	eptember 28, 2006
			30. Name and address of person who completed cause of dea	th (Item 23a) (Type, F	Print)	1: - 9	ptenler 28, 2006
	Sta		31. Date filed (Month, Day, Year) 82. Registrar	s Signature	Jan Drivey O	1	Maryland
1	Registr	-	OCT 0 5 2006	s Signature	as the second		

		Pleas	se Type or Pri	nt in E	Black In	delible Ink.	Ensure A	II Copies A	re Legib	le.		
		For			d / Depa		lealth and M	fental Hygi	ene () ()	16	31612	
		Registrar			Ce	runcate or i	Dealli	2 Date of Death	g. No.		3. Time of Death	
sicia	n	Decedent's Name (First, Middle,	_	_				Month	Day	Year		
ledica			F. Sakers,			1		October			10:00 P M	
amine	er	4a. Facility Name (If not institution,	EDC 4.11)			r Location of Death		4c. County o		a	
		Stella Maris Hos	-				nium		1		County	
eral ctor		5. Social Security Number 213-34-9148A	6. Sex 7. A		last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10-07-19	Year)	Count	ace (State or Foreign try) rland	
		Usual Residence of Decedent		10- 00	T					1/	Od. Inside City Limits	
=		10a. State 10b. County		10c. Cit	y, Town or Lo					1	XXYes 2 No	
9	rector	Maryland N/A				Baltimo	ore					
2	Ole D	10e. Street and Number				10f. Zip Code		10	g. Citizen of W	What Country? USA		
		3323 Chestnut Av	enue :			2	21211					
1	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U	.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race	- America		
9		1 ☐ Never Married 2 Marrie	ed 1202 Yes 2 [1 ☐ Yes 2KNo			Specify:			
2	ğ	3 Widowed 4 Divorced	Year or Dates	:					Оросиу.	Whi		
lea	etec	15. Decedent' (Specify only highest	s Education grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done	pation during most of work d)	ring 1	6b. Kind of Bus	siness/Ind	ness/Industry	
3	Completed	Elementary/Secondary (0·12)	5+)		DO NOT use retired achinist	d)		Airplar	no Da	rtc		
8	ပ္ပ	11		10	aciliiisc					u. CS		
	To Be C	17. Father's Name (First, Middle, L William F. Saker				*		e (First, Middle, M ta Virgin			1	
E E		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address (Street	and Number or Rur	al Route Number,	City or Town, S	State, Zip	Code)	
ar tra		Sandra E. Sakers	s wife		3323	21211						
oth		20a. Method of Disposition		1	. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - Ci						wn, State	
7 0		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Θ		matory		1/2006	atonsvi	ille,	MD	
2 .		21. Signature of Funeral Service L	4	/ 		2. Name and Addre						
eny i		In the H	(4.0	1.	B	urgee-Her	nss-Seitz Road Ba	Funeral	Home,	Inc.		
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caus	ed the deat	h. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	st,		Approximate	
		shock, of heart failure List of Immediate Cause (Final	-V							41.7	Interval Between Onset and Death	
ian	disease or condition resulting in death) a.									-		
ner			Due to (or a	s a consec	(uence or):							
	_	Sequentially list conditions,	b. Due to (or a	s a consec	more and of							
sit	in a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			,,-							
-tran	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consec	ruence of):							
buria												
ti et	g		d									
se as	/Me	IF FEMALE:	23c. If yes, outcom	e of orego	ancv				23d. Date	of daling	201	
j j	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Feta	al death 3	☐Ectopic pregnanc ☐ Other (specify) _	у		Mon		Day Year	
iched for use as the burial-transit	yslclan/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnant 9⊟Unknown	at three of C	1 0 4111 5[_ Опет (ѕреспу) _						
# I	C											

Physic /Med Exam

Ph

Fun Dire

death with the Maryland

permit. Pages 1 end 2 should be tiled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23s or 28s-f show

Baltimore, Maryland 21215-0036

10:00 p.m.

OCTOBER 2, 2006

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificete has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by

WILLIAM SAKERS

23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 🛣 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 2**X** No 1 ☐ Yes

26. Place of Death (Check only one)

TIMONIUM, MD 21093

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼No 27. Manner of Death 1 X Natural 2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 28b. Time of Injury 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 10/3/06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State 2006 5 Registrar 0

2300 DULANEY VALLEY RD.

			1 - For State Registrar	State of Ma	ryland / [Departmen Certificati				ene 2006	31613
	Physici		Decedent's Name (First, Middle, Last) Frede		Schilp;)			2. Date of Death Month October	Day Year 1 2006	3. Time of Death 12:00 A. M
	/Medi Examir		4a. Facility Name (If not institution, give s				Town, or Lo	ocation of Death	october	4c. County of Dea	
			Manor Care Nu				atons			Baltin	nore
	Funeral Director		217 03 1742	, ,	(In yrs. last bir 88	Yrs. If Under Months		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) July 5,	(ear) 9. Bir 1918 Mai	thplace (State or Foreign ountry) cyland
	ow ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
	e-fah	ctor	Maryland Baltimon	re	Ba1t	imore					1 ☐ Yes 2 📉 No
	th with th	al Directo	10e. Street and Number 3200 N. Rolling	g Road		10f. Zip	Code 2124	.4	100	g. Citizen of Whal Co	ountry?
36	urs after dea il', or iteme	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Endemod Forces? 1 ☑ Yes 2 □ Note of Yes, Give Year or Dates:		13. Was Deced		anic Origin? (Spe Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
215-0(ithin 72 hou 18. 18n "nature 1 Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) , College (1-4or 5+	16a.		rk done duri e retired)	n ng most of workii	ng	Sb. Kind of Business	Industry
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Heatin and Mental Hygiene. Important: If term 72 is marked other than "natural", or items 23 or 28s-f show any injury or other treumatic event, the Madical Examinar must be notified at once.	To Be Cor	17. Father's Name (First, Middle, Last) Freder	4 years		upervisc			(First, Middle, Ma 1. Georgi		
, Mary	and 2 shou alth and N 27 is mar		19a. Informant's Name/Relationship (Typ. William Schilpp /		19b. 32	Mailing Address	(Street and	Number or Rura Road		ore, Maryl	
Baltimore,	Pages 1 and of He Int. If Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemeter	Disposition (Narry, crematory or of Hill Cer	ther place)			oc.Location-City or altimore,	
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service License	muse	whi	22. Name and 4001 R	d Address d	of Facility Go e Highwa	nce Fune y Balti	ral Servio more, Mary	ce, P.A. yland 21225
	Physician /Medical Examiner	-	23a. Part I. Enter the disease, or complic shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	e cause on each line	Consequence	onta	e of dying, s	uch as cardiac o	r respiratory arresi		Approximate Interval Between Onset and Death
8760, S	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a							
.O. Box 6	the death certific by the attending p ached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death	3 □Ectopic pre 5 □ Other (spe	egnancy ecify)			23d. Date of deli Month	very Day Year
ds, P	w requires that the de been signed by the is should be detached	þ	Part II. Other significant conditions cont	tributing to death but	not resulting in	the underlying ca	iuse given ir	n Part I.	23e. Did tobac	cco use contribute to	the cause of death?
<u> </u>	The ate h page	e Completed	25. Was case referred to medical						24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
Vital	s cert	To Be	examiner?	ospital:	2 ER/Out	patient 3 DO	100-		Check only one	e 6 ⊡Other (Spec	
Division of	After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)			c. Injury at Work?		8d. Describe how		nry)
	- 2.2 -	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, far (Specify)	m, street, factory,	office	2	8f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital of within 24 hours ef To the Funeral Dicompletely filled in	edlcal	29a. Certifier (Check only one) 1 Certifying Physical Certification Physical Certification Physical Certif	ician: To the best of er: On the basis of e and manner state	xamination and	death occurred a /or investigation,	t the time, o	date and place, a on, death occurre	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
!	To the To the complet	Σ	29b. Signature and title of certifier	hlute	M.C		License nu		29d.	Date signed (Month	Day, Year)
	(3)		30. Name and address of person who con	inploted cause of dea	th (Item 23a) (4 0 5 +	Type, Print)	de R	d.# 200	z, Balt	ctober Z, More, MO	21228
	Sta Registra	-	31. Date filed (Month, Day, Year) GCT 0 5 200	32. Hojstrar's	s Signature	1 10					

DHMH 17 Rev 1/2001

-			1 - For Registrar	State of Ma	aryland / Depa	artmen rtificat			d Me	ental Hy	gien Reg. N		16	31614
	Physic /Medi		Decedent's Name (First, Middle, Last) Evelyn F. Thomas						1	2. Date of De Month 10	aath Da	j ^y 2	2006	3. Time of Death 6:25 p _M
	Exami	ner	4a. Facility Name (If not institution, give second Sec			Fall	ston	ocation of D		-	Ha	arfor	<u></u>	
	Funeral Director		5. Social Security Number 6. Sex 220-12-0468	7. Age	(In yrs. last birthday) 81 Yrs.	If Under Months	Days	Hours N		3. Date of Bir 9 / 20 / 1	925)	9. Birthpl Coun Mary	ace (State or Foreign try) Tand
	the Maryland r 28a-f show	rector	10a. State 10b. County MD Harford 10e. Street and Number		10c. City, Town or Lo Fallston	cation	Code				10g. C	itizen of Wi		0d. Inside City Limits 1 ☐ Yes 2XXNo
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event. The Medical Examinar must be notified at	eted by Funeral Director	2131 Buell Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade		0 16a. Deced	210 Was Deced f Yes, spec	47 dent of Hisporty Cuban,	Specify:	uerto Ri		U.S	5.A. 14. Race	- America , White, e	an Indian, atc. te
and 2121	d be filed within intal Hygiene.	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) James Marion Wilk	College (1-4or 5-	F)]	Tell	er		Name (First, Middle,)	
ore, Maryland	0 0 == =	T	19a. Informant's Name/Relationship (Ty) Mr. Albert J. Thomas / 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R	Print) Husband		Buel sition (Nan	1 Dr.	• Fal	Rural I	Route Number	er, City 21(or Town, S		
Baltimore,	permit. Pages Department of important: if it any injury or o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Wasandwa Sch		ir ia bates	. Name an	d Address	-	Lec	006 onard Baltim	J. F	kvill Ruck, MD 2	Inc.	
	Physician and /Medical Examiner step private transit step private transi	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of): consequence of):	re	nul	Cu	n Ce	<u>-1</u>				Interval Between Onset and Death Ment
Box 6	death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Petal death 3□	Ectopic pre Other (spe						23d. Date Monti		y Day Year
Δ.	The law requires that the te has been signed by th vage 2 should be detache	þ	Part II. Other significant conditions conf	ributing to death bu	t not resulting in the un	derlying ca	luse given	in Part I.		23e. Did to				e cause of death?
	10 17	e Completed	25. Was case referred to medical				2	% Place of F	Peath //	24a. Was autop perfo 1 Yes	rmed?	pride	ere autop or to com ath? Yes 2	sy findings available pletion of cause of
vision of	tending Physieath. tor: After this the funeral dir	Certification; To B	examiner? 1 Yes 2 No Ho 27. Magner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	ospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	Year) 28b. Time of Injury	M 28	Other: Bc. Injury at Work? 1 Yes	4 🗌 Nursing	Home 280	94 Resid	dence now inju	nd Number	i	Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical Ce	29a. Certifier (Check only one) 1 Certifying Physic Check only one)	cian: To the best of er: On the basis of e and manner state	my knowledge, death examination and/or invest.	occurred a	t the time, in my opin	date and pla	ice, and	d due to the o at the time, o	cause(s date and	and mann d place, and	er as sta d due to t	ted. the cause(s)
)	Totl withi Totl comp	W	29b. Signature and title of certifier	ni	_m,		License n	184	/			te signed (ay, Year)
	Sta	te	30. Name and address of person who con Dr. Ban ran 31. Date filed (Month, Day, Year)	32. Registrar	's Signature	Print)								

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		·	1 - For State Registrar	State of Maryla		artment of rtificate of			2006	31615
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Lass Helen 4a. Fecility Name (If not institution, give	Trombero		4b. City, Town,	or Location of Death	October	Day Year 200	
	Funeral Director	ler	1822 Elk Road 5. Social Security Number 6. So		s. last birthday) Yrs.	ESSEX If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y 5/9/1914		e hplace (State or Foreign wryland
	ith the Maryland or 28a-f ehow	Director	10a. State 10b. County Maryland Baltimo		city, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐XNo
-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 le marked other then "neturel", or Iteme 23s or 28s-1 ehow other treumatic event, Its Medical Examinar must be notified at	by Funeral	10e. Street and Number 1822 Elk Road 11. Marital Status 1 Never Married 2 Married **Widowed 4 Divorced 15. Decedent's Ed	12. Was Decedent Ever in Armed Forces? 1	16a. Dece	1 ☐ Yes XX No	upation	pecify Yes or No- Rican, etc.)	J. S. A. 14. Race - Ame Black, Whit Specify:	ncan Indian, a, atc. White
21215-0036	filad within 72 Hygiena. Ither then "ne ent, Ita Madic	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retir	e during most of work ed)	ding (Own Home	
Maryland	2 should be filad and Mantal Hygi Ie marked other eumatic event, II	To Be (17. Father's Name (First, Middle, Last) William Heinz 19a. Informant's Name/Relationship (7)	enberger	10b Mailir	an Addrage (Strag	18. Mother's Nam Louise at and Number or Rui		ney	Zin Code)
	gas 1 and 2 si t of Health an if item 27 ler or other treur		Raymond H. Trombe	ero (Son)	1811	I Elk Rossition (Name of matory or other pl	ad Essex,	Maryland		
Baltimore,	permit. Pages Department of Importent: If it eny injury or o		4 Donation 5 Other (Specification 2)	Lo	Bi	ark Ceme Name and Addi uzdzins	ress of Facility ki Funeral	L Home PA	altimore,	
	Physician /Medical Examiner		23a. Part I of the disease, or composition of the disease, or composition to the disease of condition resulting in death)	a. Due to (or as a conse	ath. Do not ent	er the mode of dy	Eastern Av ring, such as cardiac refi°d n			Approximate Interval Between Onset and Death
3760,	ata ba axacuted nysician and ha burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.) Due to (or as a consect.)						
P.O. Box 68	Tha law requiras that tha death certificate be as ate has been signad by tha attanding physician paga 2 should ba dalached for use as tha buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnan	су		23d. Date of de Month	ivery Day Year
	w requiras that been signad by should ba data	Ď	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause g	oven in Part I.		cco use contribute to	the cause of death?
Il Records,	: Tha law requicate has been paga 2 should	Completed						24a. Was an autopsy performe 1 ☐ Yes 2.5	24b. Were au prior to death?	utopsy findings available completion of cause of 2 No
on of Vital	ding Physician: Th h. Aftar this cardicate funeral diractor, pag	ion: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending	Hospital: 1 ☐ Inpatient 2 { 28a. Date of Injury (Month, Day Year)	☐ ER/Outpatier 28b. Time of Injury	28c. Inju	ther: 4 🗆 Nursing H	th (Check only one) ome 5 (XResidence 28d. Describe how	ce 6 Other (Spe	cify)
Division	or Atten after daat Director; in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	}	home, farm, str			28f. Location (Stree City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospitel within 24 hours. Yo the Funerel completely filled	Medical	(Check only 2 Medical Examone)	ysician: To the best of my kr niner: On the basis of examin and manner stated.		vestigation, in my		red at the time, date		to the cause(s)
,	7 3		29b. Signature and little of certifier 30. Name and address of person who	Primary Car	e Physic					14, 2006 MD 21204
) Sta Registi		Richard O. Ad 31, Date filed (Month, Day, Year)	do Mo- 32. Hegistral's Sign	8 415	Bellon	a Lane	#216,	Towson	MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 006 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** THOMPSON STEPHANIE OCT 5:59 PM 02 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Falkirk Road Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Ol. 27. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 212.58.1031 1 □ M 2 🕶 F 55 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State iral', or Itams 23a or 28a-f show Examiner must be notified at Baltimore MD 1 WYes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6520 Road Apt. D US4 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If itam 271s markad othar than "natural", or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
II Hugrade College (1-4or 5+) Clerk itam 27 Is markad otha othar traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Suma Be Geneva Kermit Brown Champli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Foster Road Apt SON Balto. MD 21239 Falkirk 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō = 5 fy Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Arbutus Membrial 10.09.06 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 23. Name and Address of Facility
Vallyho C. Breene Funeral Service
4905 (Mc Road Baltimore MD 21212 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician HEART FAILURE ONGESTIVE YCARR disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** KARS HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, CHROMIC DUSCASE 1 √es 2 No OBSTRUCTIVE PULMONARY 3 Probabty 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an No 1 ☐ Yes Hospital or Attanding Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a To tha Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 53904 03,2006

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Registrar

KAY THI

31. Date filed (Month, Day, Year)

05

2006

32. Registrar's Signature

NWE, 301 ST PAUL PLACE # E312, BALTIMORE, M.D 21202

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The contract of the contract o	-09.5.0.		
State of Maryland / Department of Health and Mental Hygien	006	316	17
Certificate of Death Ben No.		•	

			1 - State Registrar	•	Cer	tificate of	Death		Re	g. No.	000	0 1 0	. ,
			1. Decedent's Name (First, Middle,	Last)				2.	Date of Deat Month	h Day	Year	3. Time of	
	Physici /Medio		Mary Tack	a					9	29	2006	11:37	P M
	Examir		4a. Facility Name (If not institution, g	rive street and number)		4b. City, Town, o	or Location of	f Death		4c. C	ounty of Death		
			University of Mary	lund Medical Con	fer	Baltimo							
	Funeral			. Sex 7. Age (In yrs	**	If Under 1 Year Months Days		Min.	Date of Birth (Month, Day,	Year)	9. Birthp Coul	lace (State o	r Foreign
	Director		212-34-0933	70	Yrs.			1	1/27/1	935	MD		
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					·	0d. Inside Ci	ty Limits
	f sho	٥	MD Anne An	aundal Ta	- -							1 🗆 Yes	2 🔼 No
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	hours after death with the Maryland tural; or items 23s or 28s-f show al Examinal must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.		Vas Decedent of h	Hispanic Origi	in? (Specify	y Yes or No-		I. Race - Ameri		
٥	after or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No		Yes, specify Cub		, Риепо ніс	an, etc.)		Black, White,		
3	rai',	by	3 ⅓Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		☐ Yes 21忆 No	Specify:			S	Specify: Wh	ite	
9500-61212	be filed within 72 hours after death with the Marylar ital Hygiena. Id other than "natural", or items 23s or 28s-1 show of other than "natural", or items 23s or 20s-1 shown. The Madical Examinat must be notified at	Completed	15. Decedent's (Specify only highest of		(Give	lent's Usual Occup	durina most	of working		16b. Kind	d of Business/In	dustry	
7	within 72 ena. than "nat	ηpi	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retire	ed)				_		
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Ĕ	d Men narke	5	Richard Dorsey I		105 Maille	- 4-1 (00	1	.known		0	T Ct-4- 7:	0-4-1	
Mary	s 1 and 2 should I Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship			g Address (Street						(Code)	
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≣	nit. Pa artmen ortant: injury		4 □Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice			. Name and Addre							
ñ	Departicular Depar		17/1/ A	Vanue / Ma		Second							
п			23a. Part1. Exter the disease, or co	implications that caused the death								Approximate	9
	Physician		shock, or heart failure. List on Immediate Cause (Final	A 1		1 .1.					7.	Onset and I	Death
	/Medical	11	disease or condition resulting in death)	a Cardio 420		hock					-	e hour	2
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ک ک	ertific ding p	We.	IF FEMALE:	22a If was autooms of propos									
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ŗ.	that the ded by deta	Ph/	Part II. Other significant conditions	contributing to death but not rest	ulting in the ur	iderlying cause gr	ven in Part I.		23e. Did tob	acco use	e contribute to ti	ne cause of d	eath?
S	requires that the reen signed by th hould be detache		Chronic Obst	rective Pulma	raves.	D. seaso			1 XYe	s 2 🗆	No 3 ☐ Prot	ably 4 🗆 t	Inknown
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2	ysick is cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1⊠Inpatient 2□	ER/Outpatien	t 3□ DOA Ott	har				Other (Specif	v)	
יס ר	g Ph ter th		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo			l. Describe ho			···	
ğ	ath. or: Af	atic	1 2/Natural 5 Pending 2 Accident investigat	ion	,2.,]Yes 2□N	10					
UNISION	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		me, farm, stre	eet, factory, office		28f.	Location (Sti City or Town		Number or Rura	I Route Num	ber,
2	oital ours af	ပိ	V										
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2.	edical	29a. Certifier (Check only one) Certifying (Check only one)	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the ti restigation, in my	ime, date and opinion, death	d place, and h occurred	I due to the ca at the time, da	iuse(s) ai ite and p	nd manner as s lace, and due to	tated. the cause(s)
	To the Within To the Somple	Me	29b. Signature and title of certifier	2		29c. Licens			29	d. Date	signed (Month,	Day, Year)	
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	10		30. Name and address of person when \mathcal{N} 4 \mathcal{W} 94				, (0-1	1	,	MD	Rob	ent
			31. Date filed (Month, Day, Year)	32 Registrar's Signa	ee ne	Stree	2 1	1)41	Dunar	e	111)	10	itan
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2005 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 29, 2006 9:26 AMM Gabriel Umoh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Montgomery Olney If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 24, 1956 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Country) Nigeria 1 ☑ M 2 ☐ F Yrs 70 Director 234-15-1527 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Prince George's Hyattsville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2116 Ravenswood Street 20782 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) post office h and Mental Hygier 7 is marked other th unk unk unk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any light you other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Akban Umoh ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Akban/friend/landlord 2116 Ravenswood Street Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ☑Other (Specify) in starte State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 25a. Parkt, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any cause the Underlying Cause (Disease or injury Due to [or as a consa uence of] or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 Dunknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 ☐ Yes 2 D∕No 25. Was referred to medical examiner?

12 Yes 2 No Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Aftert 1 Natural 5 Pending Injury death. 1 Tes 2 No 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the i 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signar reand tit 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) U 31. Date filed (Month, Day, Year) 32/Registrar's Signature State 0 5 2006 Registrar

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of			ien e 0 0 (6 31619
3	Physici /Medic		1. Decedent's Name (First, Middle, Las Tavvol)		Viese	io		2. Date of Deal Month		3. Time of Death
	Examir	100	4a. Facility Name (If not institution, give GOOD SAMARITAN F.	OSPITAL		BALTI	or Location of Dea	Y	4c. County of N/	A
	Funeral Director		5. Social Security Number 6. Sec. 118-16-0429 Usual Residence of Decedent	X 7. Ag	99 (In yrs. last birthday 89 Yrs.	Months Days			977	9. Birthplace (State or Foreign Country) NEW YORK
	a-f show	ctor	10a. State 10b. County MD N/A		10c. City, Town or I					10d. Inside City Limits 1 X Yes 2 No
	ath with the 23a or 28	ral Director	10e. Street and Number 1548 SHERWOOD AVE				1239		0g. Citizen of What USA	
9036	within 72 hours after death with the Maryland ene. then "natural", or Itema 23a or 28a-f show fra Madleal Exartirar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🛣 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	,	. Was Decedent of if Yes, specify Cu		Specify Yes or No- erto Rican, etc.)	Black,	· American Indian, White, etc. WHITE
21215-0036	d within 72 hagiene.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12TH GRADE	ucation de <i>completed)</i> College (1-4or :	(Giv	edent's Usual Occi e kind of work doni DO NOT use retir	during most of w	orking	16b. Kind of Busin	ŕ
Maryland	should be filed nd Mental Hygi marked other imatic event, II	To Be C	17. Father's Name (First, Middle, Last) GUISEPPE VESCIO					ame (First, Middle, I		
Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or itema 23a or 28a-f show any injury or other traumatic event, II a Madical Examinar must be notified at once.		19a. Informant's Name/Relationship (7. SHERNA F. BARKSE 20a. Method of Disposition 1 \(\begin{align*} \text{1} \\ \text{Densition} \\ \text{2} \\ \text{Donation} \\ \text{5} \\ \text{Other (Specify)} \\ 21. Sign tup of Funeral Service Licenses	OALE	20b. Place of Discometery, or ST. PETI	N. CALVE	RT ST.	/6/2006 HE JOHNSO	, MD 21 20c. Location - Cit ROME, N	202 ity or Town, State
8760;	Physician and // Medical Examiner sthe pural-Iransit	dical Examiner	23a Part1. Enter the disease, or compositions, or heart failure. List only of the classes or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pour to (or as b. Due to (or as c. Ruy	Jhe death. Do not emb. UNON a consequence of): a consequence of): JAN A consequence of):	egestivit		ac or respiratory arm		Approximate Interval Between Onset and Death LIRS Thorn OUL Howth
.O. Box 6	death certif e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnani □ Other (specify)	су		23d. Date of Month	,
S, D	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions co	ntributing to death b	out not resulting in the	underlying cause g	iven in Part I.			ute to the cause of death?
Vital Record	n: The law ra icate has be r, page 2 sh	Completed						24a. Was a autops perform	y prid ned? dea	ore autopsy findings available or to completion of cause of ath? I Yes 2 1 No
o	To the Hospital or Attending Physicism: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	atlon: To Be	27. Manner of Death 1 SNatural 5 Pending investigation	26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Cther. 4 Nursing Home 5 Residence 6 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Mork? M 28c. Injury at Work? M 1 Yes 2 No						
Division	ital or Atters as all Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined		jury - At home, farm, s c. <i>(Specify)</i>	treet, factory, office		28f. Location (St City or Town	reet and Number n, State)	or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Direction completely filled in I	Medical	one) 21 Medical Exam	sician: To the best iner: On the basis o and manner st	of my knowledge, dea if examination and/or i ated.	nvestigation, in my	opinion, death occ	curred at the time, d	ate and place, and	d due to the cause(s)
	To with		29b. Signature and title of chriftier	rupe	uacen	D 29C. LICER	3066		ou. Date signed (1	Month, Day, Year) 2006
	10		30. Name and address of berson who co	ven,	alva, 6	Print) Laction	rele,	Kd - "	2123	39.
大学の	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 5 200		ar's Signature	ander				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 0 6 31620 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3_ 2006 1:50 AM M Jean H. Victor October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Keswick MultiCare Center N/A Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 218-28-4927 74 Yrs. June 4, Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location item 27 is marked other then "neturel", or Items 23e or 28e-1 show other treumetic event, the Medical Examination rules be inclided at XX Yes 2 No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 821 W. 35th Street 21211 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married 1 Yes 2XXVo Baltimore, Maryland 21215-0036 Specify white 3 ⊠ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker In own home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be if Health and Mental item 27 is marked o Marie Hubbs Charles Kenny 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gary D. Victor Son 821 W. 35th Street Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition • <u>=</u> 1XX Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery permit. Page Department of Importent: If eny injury or 10/6/2006 Parkville, Maryland 21. Signature of Juneral Service 1 22. Name and Address of Facility Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximations. Burgee-Henss-Seitz Funeral Home, Inc. Approximate Interval Between Onset and Death Immediate Cause (Final 2 pS1 veeks Physician disease or condition resulting in death) /Medical Examiner hron Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit DKE that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performe 1 ☐ Yes 2 ☐ No certificate 2 No 1 Yes of Vital 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4- Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 ☐ No this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 1 Natural 5 Pending within 24 hours are: Vita to the Funerel Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 - Homicide Hospitel 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the h 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of date (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar 2006

			For State Registrar		State o	f Marylaı	•	artmen <i>rtificat</i>				ental Hyg	giene	0 0)6	3	1621
	Physici	an	1. Decedent's Name (First, Mi	ddle, Last))							2. Date of Dea	ath		20 06		me of Death
	/Medic Examir	cal	Jean Dale Var 4a. Factor Name VI noting till			mberl (man	nter	4b. City,	Town, or	Location	of Death				A State		
				•											Dell	1 m	ore
	Funeral Director		Social Security Number 220-52-3952 Usuat Residence of Decedent	6. Ser	M 257F	7. Age (In yrs	. last birthday) Yrs.	ff Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day June 2		47	9. Birthp Coun Mary	itry)	itate or Foreign
	yland		10a. State 10b. Cou	nty		10c. C	ity, Town or Lo	ocation					-		1	0d. Ins	ide City Limits
	8e-1 •	Director	2	rford		Fo	orest H	ill]Yes 2⊠No
	with the		10e. Street and Number					10f. Zip					10g. Citiz	zen of W	Vhat Coun	itry?	
	deeth ms 23	Funeral	1704 Rich War	Ž	12. Was Dece	edent Ever in l	J.S. 13.	Was Deced	2105 lent of His		gin? (Spe	cify Yes or No- Rican, etc.)			- Americ		an,
980	hours after death with the Maryland turel', or Items 23a or 28e-f ehow at Exantirer must be redified at	þ	1 Never Married 2 ☐ N 3 ☐ Widowed 4 ☐ Divorce		Amed Fo 1 Tes If Yes, Giv Year or D	rces? 2-≦ No ⁄e ates:	1	lfYes, spec 1 ☐ Yes			i, Puerto I	Rican, etc.)		Black Specify:	k, White, Wh	_{etc.} ite	
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Maryland 21215-0036	within iene. than "	Completed	Elementary/Secondary (0-1	2)	College (1	1-4or 5+)	Libra	po Notus rian	se retired)				Pul	blic	: Sch	ool	s
nd 2	be filed stal Hygi of other event, I	Be C	17. Father's Name (First, Midd	lle, Last)						18. Mothe	r's Name	(First, Middle,					
ylaı		To	William Dale V				C					d Dowli					
Mai	12 a 7		John R. Crouse			n-law						<i> Route Numbe</i> 'orest F					21050
ore,	of Healt of Healt filtern 2 r other		20a. Method of Disposition			20b.	Place of Dispo cemetery, crei	osition (Nan	ne of ther place	9)		ate			City or To		
Baltimore,	Pages ment of tant: If It jury or o		1 ØBurial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other	(Specify)		State	ighview	Memo	rial	1	L0 - 6-	-06	Fall	Isto	n, M	ary)	Land
Ball	permit. Page Department Important: If any injury or		21. Signature of Funeral Serv	ce Licens	A PON	unt						l Home, Abingo	P.	A.			
			23a. Part 1. Enter the disease shock, or heart failure. I	or compli	cations that c ne cause on e	aused the dea	th. Do not ent	er the mod	e of dying	, such as	cardiac o	r respiratory ar	rest,			Appro	ximate al Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-			HOCK								_	48"	Hours
	Examiner		Sequentially list conditions.	l l),	PIRAT		ILUR	E							48	HOURS
/	outed d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	【 。	ACU	TE REN		ILUR	E							48	HOURS
8760,	cate be executed physicien and the burial-transit	cal Exa	resulting in death) Last			or as a consec ER FA	guence of): LURE									48	HOURS
9	ortificat ing phy e as th	Medical	IF FEMALE:											-			
.O. Box	at the death certificate by the attending phys tached for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	2	1□Live b	come of pregn wirth 2 Fet ant at time of communications	af death 3 [DEctopic pr Other (sp					2	3d. Date Mor	e of delive	Day	Year
S, D	es that igned b	by P	Part II. Other significant cond	litions cor	ntributing to de	eath but not re	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco us	se contri	ibute to th	e caus	e of death?
ord	w requir been si should		OBESITY									1 🗆 Y	es 20	No	3 Prob	ably	4 Unknown
Division of Vital Records,	The la ete hes page 2	Completed										24a. Was a autop perfor	sy	p	rior to con eath?		dings available n of cause of
Zi:	Physicien: Tribis certificeral director, p	o Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☑ No		lospital:	npatient 2] ER/Outpatier	4 2 20	Othe			Check only or					
J Of	ding Phys n. After this funeral di	on: To	27. Manner of Death	elia a	28a. Date		28b. Time of		8c. Injury Work	4 🗀 140		ne 5 🗆 Resid 28d. Describe h				9	
sior	Attending r death. sctor: After by the fune	catio	2 Accident inve	stigation ald not be				М	1 🗆 Y	es 2 🗆 l							
Divi	el or Attens s after deat il Director: ed in by the	Certification:	4 Homicide dete	mined		of fnjury - At h ng, etc. <i>(Speci</i>		eet, factory	, office		2	28f. Location (S City or Tow			er or Rura	l Route	Number,
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical (29a. Certifier 1 Certifier (Check only one)	ying Phys al Examii	ner: On the ba	best of my knoasis of examination	owledge, death ation and/or in	n occurred vestigation,	at the time in my op	e, date and inion, dear	d place, a	and due to the o	ause(s)	and mar place, a	nner as st and due to	ated. the ca	use(s)
	To the within To the comple	Ň	29b. Signature and title of cent	11:	JM)	MO		290	License	number 15346	54	k	9d. Date	/	(Month, L	,	ear)
	10		30. Name and address of pers JASON MARX						owsc)N, 1	MARY	LAND a	2120	14-7	582		
	Sta		31. Date filed (Month, Day, Ye		32. 8	egistrar's Sign	ature					*					
DH	Registr	ali nos	OCTO	5 201	JO L	Making A	A. A.			-							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deat 1118 AM Month 0 WORRELL CORINA 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death cently medica ff Linder 1 Year | If Linder 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10 · 22 · [9]8 Birthplace (State or Foreign Country) Days 1 ☐ M 2 🛣 F 216.16 6074 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 MYes 2 No Director BATTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SARATOGA STREET 2023 W. USA 21223 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by ff Yes, Give Year or Dates: Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 403 SEAMSTRESS 12 TH GRADE CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CORRINA STACEY FRANK DEBERRY 0 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON 2025 W. SARHOGA ST. BALLO. MD 21223
ace of Disposition (Name of Date 20c. Location - City or Tow NICHOLAS BUILER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK 10.06.06 BALTIMORE 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NATU PIKE, 21. Sign ture of Fuperal Service Licensee Vaushn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY EMBOLISM DAYS Oue to (or as a consequence of): UNKNOWN LOWER EXTREMITY DEEP TIMOMBOSIS VEW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy in the past 12 menths? Month 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Diabetes Mellitus type Ti 1 Yes 2 XNo Be 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide

The law requires that the death certificate be executed burial-transit physicien and Box 68760 P.O. signed by Division of Vital Records, certificete Hospital or Attending Physician: hours after death. Inerel Director: After this y filled in by the funeral di within 24 hours at To the Funerel D completely filled it į

Physician

/Medical

Examiner

Funeral

Director

in then "neturel", or items 23s or 28s-f show the Medical Examiner must be notified at

filed within 72 hours after. I Hygiene. other then "neturel", or ite

other

permit. Pages 1 end 2 should be fift Department of Health and Mental Hy Important: if them 27 is marked oth eny injury or other treumatic event once:

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

the

State Registrar

31. Date filed (Month, Day, Year) 2006 OCT 05

29b. Signature and title of certifier

FERNANDO

29a. Certifier

Medical



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Denomo



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

7602

BALTO.

040480

BEZAIN

ROSO

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Walker Year Dubois 5:00 PM 10 01 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stevensville

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Point Rd 1008 Anne Queen DYC Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 M M 2 □ F Yrs Director 215-03-9395 5/14/1918 Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. int: if Item 27 ie marked other than "naturel", or Itema 23a or 28a-1 ehow 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-1 show other treumstic event, the Medical Examinar must be notified at Stevensville Completed by Funeral Director 1 ☐ Yes 2 ☑ No MD Queen 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Rd 1008 Love 21/06/06 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 3

Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grade NA ORderly Medica 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ FRANK D. Walker Mary Ellen Nickens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Eller Walker (daughter)
20a. Method of Disposition 1008 Love Point Rd, Stevensville, MD 21/106 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) trbutus Baltimore 10/9/2006 22. Name and Address of Facility Funeral Suc 21. Signature of Funeral Service Licensee Vaughn C. Greene 5151 Balto Not Pike, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Priysician disease or condition resulting in death) -0 lon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, frank, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ours efter death. Ierel Director: After this certificete has been signe filled in by the funeral director, page 2 should be. venous 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death | Check on yone Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours eff 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certif

31. Date filed (Month, Day, Year)

Daniel J. Konick, M.D.

OCT 0 5 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

130 Love Point

32. Registrar's Signature

29c. License number

#107

29d. Date signed (Month, Day, Year)

Stevensville, MD. 21666

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend items 7.8, per fh 9860 10-5-06 vt. State of Maryland / Department of Health and Mental Hygiene 0 0 6 31624 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Kinler 114100 10MMPV292006 6:0) MA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner naalis If Under 24 Hrs. If Under 1 Year 02ate of Birth Month, Day, 11 28 5. Social Security Number 7. Age (In vrs. last birthday) 1927 Birthplace (State or Foreign Country) **Funeral** Months Days Min **₩** M 2□ F 78 Director 219-22-3063 MD Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28e-1 ehov treumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other than "--- any injury or other treument." items 23a or 1405 Bloomingdale Road 21216 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Social Security Adm 12th grade Mail Clerk na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Estelle Mosley McKinley Whitley ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 90043 Kim Tarver-Neice 3943 West 60th Street, Los Angeles, CA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 10/2/06 Owings Mills, Md 21. Signatur, of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, md 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear valure. List only one cause on each lige.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included expects) Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events iding physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ete has been signed by the atter page 2 should be detached for u in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 14 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 0 this certificete 2 No 1 Yes 2 No 1 Yes After this certifice funeral director, 25. Was case referred to medical Be 26. Place of Death [Check only one] Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 3 OA 21 No 1 Inpatient 2 ER/Outpatient 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1.—Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation filled in by the fu 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar

State

29b. Signature and title of certifier

ERICA TOBIN

31. Date filed (Month Day, pag 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUCLUU WD 54

Market ...

5401

29c. License number

29d, Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 0 0 6 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Nathaniel Charles Jr James Weems, 5:00p.M 28 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3720 White Pine Road Middle River Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O 3 18 4 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **Д**М 2□ F 59 Director 213-92-6120 MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits ral, or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Middel River Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 U.S.A. 3720 White Pine Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bfack, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Black ģ 3 ☐ Widowed 4 ☐ Divorced "netural" th and Mental Hygiene.

I Is marked other then "netur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Various Jobs Laborer llth grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pearl E. Wallace James N. C. Weems 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1510 Pennsylvania Ave #8, Balto, Md 21217 Health Item 27 | Vanessa Reed-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages of Popartment of Himportent: If its eny injury or ot one. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 10/6/06 Randallstown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. West 4300 Wabash Ave Baltimore, Md. 21215 2/a. P.rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Imme late Cause (Final lise ase or condition e ulting in death) Onset and Death **Physician** Diabetes Mellitus /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, lany sound to muscles cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physicien and stransit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the at d be detached fo 5 Other (specify) Ö 9 Unknown 9 Unknown <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 2 🗆 No 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed Yes 2 No 1□ Yes Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be within 24 hours efter des To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059385 06 address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) WS caldo 32. Registrar's Signature State OCT 0 5 2006 Registrar

			For State Registrar	State of Ma	aryland	/ Depa	rtment of H	lealth Death	and Ment		ene 0 0	16	31626
		& 2	Decedent's Name (First, Middle, L.	ast)					2. Da	ate of Death		Year	3. Time of Death
	hysici: Medic		Peter Brooks						00	CTOBER	ROJ. 20	006	8:15 A. M
Έ	xamin	er	4a. Facility Name (If not institution, gi VA MARYLAND HEA)		STEM		4b. City, Town, o		of Death POINT		4c. County	of Death CEC	.T.
	neral ector		034-32-3251	Sex 1 M 2 F 7. Age	e (In yrs. las 62		If Under 1 Year Months Days	If Unde Hours	Min. Jul	ate of Birth fonth, Pay, y 16,	1944	9. Birthpl Coun New	lace (State or Foreign try) York
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VICAL ician: 1	ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth		ce of Death (Che	ck only one)		
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UNISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific	in by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	ury - At hom c. (Specify)	e, farm, stre	et, factory, office			ocation (Str ity or Town,		r or Rural	Route Number,
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NAME KNOWN TO PHYSICIAN: PETER WATSON

			1 - For State Registrar	State of M	1 arylar				lealth a		-	giene ()	06	31	627
	Physici	ian	1. Decedent's Name (First, Middle,								2. Date of De Month	ath Day	Year	3. Time	e of Death
	/Medi		Roger Wayne								OCT	02	2006		734 M
è	Examir	ner	4a. Facility Name (If not institution,	10			4b. City,	Town, or	Location		4c. County of Death				
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	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside	e City Limits
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9	of He of He roth		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	me of other plac	e)		Date	20c. Location			
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ă	leath atter	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic p						ate of delive onth	Day	Year
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11			30. Name and address of person wh				Print)								
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ORIGINAL

DHMH 17 Rev 1/2001

06-07089 Isaac Wright Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Date of Death Physician/ Month Day Y September 19, 2006 **Medical Examiner** 1615 hrs Isaac Wright 4a, Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death 1102 Druid Hill Avenue Baltimore, MD 5 Social Security Numberunk 6. Sex If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) Months Days Hours Director 57 Country) Oct 28, 1948 Usual Residence of Decedent 10d Inside City Limits 10a. State unk 10b. County 10c City, Town or Location unk unk 1 Yes 2 No 28a-f shov hours after death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? unk notified at unk USA or items 23a unk Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces? White, etc. 1 Never Married Married unk Yes No Widowed If Yes. Give Year Yes 2 X No specify: Specify: black "natural", ≥ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) ges 1 and 2 should be filed within 72 ho it of Health and Mental Hygiene :: If item 27 is marked other than "na other traumatic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 unk unk 17 Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk or other traumatic event, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore, MD 21201 20a Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State crematory or other place) Pages 1 Department o state Other Specify in 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Six ature of Funer I Service Lio **W**ireetor Rart I. Enter the disease, or complication failure. List only one cause on each line Approximate Interval **Physician** ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and /Medical Death Narcotic intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED AMENDED item#23a,27,28a-f,perME,g860, 10/17/06 TT Box 68760 attending phys IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. 23e. Did tobacco use contribute to the cause of death? ₽ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? After this certificate ✓ Yes 2 2 No 1 🗸 Yes 25 Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 Other₄ ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other Scene 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 Yes 2 X No To the Funeral Director: completely filled in by the Fnd 9/19/2006 Fnd 4:10 pm unk Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1102 Pruid Hill Ave. 1210 Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc X Could not be Suicide Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 20, 2006 Mound and address of person o comple of cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 31629 Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** September 12, 2006 8:00 PM Whitehurst Marguritte /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Name (If not institution, give street end number) Examiner Prince George's Adelphi HHCC-Adelphi If Under 24 Hrs. B. Date of Birth (Month, Day, Yeer) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** Months Deys 1 □ M 2 1 F 96 Yrs. North Carolina Jan 19, 1910 Director 225-28-7515 Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be nutified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director MD Prince George's Greenbelt 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 20770 USA 6227 Springhill Court #102 Be Completed by Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: black Specify: 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) healthcare unk nurse unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Thomas Frasier ဥ 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1809 Mt. Pisgah Lane #23 Silver Spring, MD 20903 Carol Otu/granddaughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donetion 5▼Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Eunemal Service Licensee Ronald S. Wadd, Director 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death **Physician** THEROSCLEROTIC CARDIOVASCULAR DISEASE /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner ettending physician and for use as the burial-transit or Attanding Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760 Due to (or as e consequence of): resulting in death) Last 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. funeral director, page 2 should be deteched 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION. edical Certification: To Be Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? FAILURE TO THRIVE 24a. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 No 1 Tes 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA this 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 27. Menner of Death 5 Pending investigation Injun 1 Naturel 2 Accident ours efter death.

neral Director: Aft
filled in by the fur 1 Yes 2 🗆 No 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral I completely filled To the Hospital i Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated.

I Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D42403 9-26-06

State Registrar

31. Dete filed (Month, Day, Year) 32. Registrar's Signature 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RATHUR 106 IRVIN IRVINGSTREET, WASHINGTON D.C 20010

State of Maryland / Department of Health and Mental Hygien 2006 3 | 630 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician October 3, 2006 Patricia Ann DOOW 12:15 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Street

Baltlikole

7. Age (In yrs. last birthday)

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. (Month, Day, Year)

April 3, 1947 Home; 1167 Nanticoke Street N/A Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2 216-48-2137 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10c. City. Town or Location r 28a-f ehow 10b County MD Yes 2 No N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be a 1167 Nanticoke Street 21230 death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XNo If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify. white 3 ☐ Widowed 4 X Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Us Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In own home 12 ith and Mental Hygie 27 is marked other r traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Allan Bunce Mazie Rose James မ Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William T. Lauer Son 102 Apt. F Warwickshire Lane Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5 = 6 1 ☐ Burial ZXXCremation 3 ☐ Removal from State permit. Page Depertment of Important: if eny injury or once. 10/6/2006 Catonsville, MD Metro Crematory 4 Donation 5 ☐ Other (Specify) uneral Service License 21. Sign util Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between 13 Months Immediate Cause (Final Non-Small Lung Cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine or Attending Physicien: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12\footnotes?
1 \(\subseteq \text{Yes} \quad 2 \(\subseteq \text{No} \) Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ed by the signed be de 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ XXYes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation f Director: A 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a
To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated [2] Medical Examiner: On the basic of examination and/or investigation 20a Cartilla Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier D0055065 October 4, 2006 30. Name at address alson who completed cause of death (Item 23a) (Type, Print) Martin J. Edelman, M.D. 22 S. Greene St. N9E08, Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0.5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 31631 Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last)

Phys /Me Exa

Funer Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 te marked other then "naturel", or Iteme 23a or 28e-f ehow eny injury or other traumatic event, the Modical Examinar mant be notified at

Baltimore, Maryland 21215-0036

XECOMINOS,

Physicia /Medica Examin

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

hysici /Medic		Hoberta Mae Xecominos		October 3	2006 Yeer	7:30a M				
Examin	_	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Locetion of Death		4c. County of Death					
		GREATER BALTIMORE MEDICAL CENTER	TOWSON		BALTIMOR					
uneral rector		5. Social Security Number 6. Sex 1 M 2X F 7. Age (In yrs. last birthda) 66 Yrs.	Monthe Dave House Min	8. Date of Birth (Month, Day, Ye 1ay 29, 1	ar) Cou	pplace (Stete or Foreign yland				
*	}	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation			10d. Inside City Limits				
e a	៦	Maryland Baltimore Co. Nott	ingham			1 ☐ Yes 2 NO				
289	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	untry?				
38.0		8616 Castlemill Circle	21236	1	United St	ates				
E I	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White					
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27 te		, , , , , , , , , , , , , , , , , , , ,	6 Castlemill Circle		gham, MD	21236				
othe etto		20a. Method of Disposition 20b. Place of Dis	position (Name of Dematory or other place)	ate 20c	. Location - City or	Town, State				
int: #		1 K Burial 2 Cremation 3 Hemoval from State		5, 2006	Cub Hill,	Maryland				
port y inju		21. Signature of Funeral Service Lieensee Michael E. Canapp	22. Name and Address of Facility	Ва	ltimore,	MD 21214				
E = 9		Misse. Copp	Leonard J. Ruck, I)5 Harford					
		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heert faifure. List only one cause on each line.	nter the mode of dying, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death				
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signed bed	Completed by Phy	Part fl. Dther significant conditions contributing to death but not resulting in the HYPERTENSION. HYPERLIPIDOMIA. OBES.		1 ☐ Yes		the cause of death? obably 4 \textsqUnknown				
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9e 2 s	μ	DIABETES WITH NEUROPATHY		24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of				
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iter th		27. Magner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28b. Time (Month, Day Year)		8d. Describe how	njury occurred					
the fu	catic	2 Accident investigation	M 1 Yes 2 No							
Direct in by	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, S	t and Number or Ru tate)	irai Houte Number,				
To the Funerel Director: After this certificate has been signed by it completely filled in by the funeral director, page 2 should be detach	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and martier stated.								
To the	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Monti	h, Dey, Year)				
		harry	00036302	110	13/06	>				
0)		30. Name and address of person who completed cause of death (ftem 23a) (Typ								
			es St. Suite 606	Towson, M	D 21204					
Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 0 5 2006	and a							
		HILL V C LOVE								

State of Maryland / Department of Health and Mental Hygiens, 31632 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 10 02 11:10pM Yates Charles /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 05 20 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year) **Funeral** Months Days Hours XXM 2□F 72 Yrs. NC 243-46-7304 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location worle if Health and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23a or 28e-f ehov other traumatic event, Ite Madical Examinar must be notified at 1 Yes 2 No Baltimore Director NA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21230 Road 2924 Rayshire Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 end 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other then "natural", or ite 1 Yes Molt No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) St. Joe Paper Co. Machine Operator 10th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emma Dickson John Yates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2924 Rayshire Road, Baltimore, Md Julia Cheeks-Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of H ant: if Ite XXBurial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Depertment of Important: If eny injury or once. 10/6/06 Pikesville, Md 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md Approximate fnterval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** M +AtzaKe resulting in death) /Medical Due to (or as a consequence of): Examiner S yuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in list and out of the cause). Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funaral Director: After this certificete has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-fransit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2□ No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify Hospital: 1 ☐ Yes 2 ☐ No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 07520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto. Md 2:208 BMC 6701 ۵ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygien 2006 31633 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Рм **Physician** 2006 6:45 09 Charles Joseph Zimmerman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A Baltimore Harborside Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**] M 2□ F Yrs Maryland Director 216-18**-**9727 83 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow the Mudical Examiner must be notified at 1 X Yes 2 □ No MD N/A Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 U.S.A. 5433 Omaha Avenue death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 No Specify: Specify: δ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. Steel Worker Bethlehem Steel 8 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 ie marked othe eny liury or other traumatic event pice. 17. Father's Name (First, Middle, Last) Agnes B. Caulfield Charles J. Zimmerman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Linhigh Avenue Baltimore, Maryland 21236 Patricia A. Loukota, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith Cemetery 10/03/2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. Maxandra 5305 Harford Rd. Baltimore, MD 21214 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Dementio year< /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physicien by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3☐Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 100 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ္ရ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 000 52928 Low mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD STEZOE BAITIMORE MD 21231 MARY ANNE NOIRY MO 4924 CAMPBELL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year OCTOBE N_ ATKINSON 50 **Physician** LUTHER JUNIOR 03 2006 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE REHABILITATION EXTENDED CARE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 141. 28 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-20-4919 10M 20F North 79 Yrs. Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other treumatic event, the Model Examination must be motified at 1 Tyes 2 No Director Yary and 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturel", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: lac 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Motor Coach Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lorraine Jane 19a. Informant's Name/Relationship (Type, Print) of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Deurial 2 Cremation 3 Removal from State ¹ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CAN CON ROSTATE YEARY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 LUNG CARCINOMA OF 1 Yes 2 No 3 Probably Completed DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an IH PERTENSION 2 No Yes after death.

Director: After this certific.
I in by the funeral director, To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 24 hours a 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30272 smiller 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 LOCH RAVEN BOULEVARD BALTIMORE MILLER MO THOMAS S.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2006

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32. Registrar's Signature

			For State Registrar	State of Marylan	·	nt of Health and ate of Death		giene neg. No. 2008	31635
	Physici		1. Decedent's Name (First, Middle, Las Ma Hhew)	t)	Brou)()	2. Date of Dea Month		3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give Johns Hopkins Bayu	new Medical (enter 4b. Cit	y, Town, or Location of Deal Baltmare	2	4c. County of Dea	IA
	Funeral Director		5. Social Security Number 6. Security Number 6. Security Number 11 Usual Residence of Decedent	ox 7. Age (In yrs.	Yrs. Month				thplace (State or Foreign ountry)
•	within 72 hours after deeth with the Maryland ene. than "returel", or tleme 23s or 28s-f ehow the Madical Extrainer must be notified at	irector	10a. State 10b. County MARYLAND 10e. Street and Number	10c. Cit	ty, Town or Location	BALTII	10RE (7/7/ 10g. Citizen of What C	10d. Inside City Limits 1 X Yes 2 □ No ountry?
9	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelih and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or Items 23a or 28a-f show apprintury or other traumatic event, the Medical Extendings must be notified at once.	Funeral Director	11. Marital Status 1 Never Married 2 Married	2EWAV 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer 2000)	Specify Yes or No- to Rican, etc.)		erican Indian,
Maryland 21215-0036	hin 72 hours 9. An "neturel", Medical Exp	Completed by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Ed (Specify only highest grants) Elementary/Secondary (0-12)	Year or Dates:	16a. Decedent's Us	sual Occupation work done during most of wo	orking	Specify: 92	LACK VIndustry
and 21	ld be filed wil ental Hygien ked other th Ic event, the	To Be Con	8 FHGRADE 17. Father's Name (First, Middle, Last) WILLIE	,	BROWN	18. Mother's Na	me (First, Middle,	SELF-E Maiden Sumame)	ARK
e, Mary	1 end 2 shou Heelth and M Iem 27 ie mar sther traumat	-	19a. Informant's Name/Relationship (7	(BROTHER)	1929 H	iss (Street and Number or R	n. 1	r, City or Town, State, PLT/HORE 20c. Location - City or	40 21239
Baltimore,	permif. Pages Depertment of Important: If if eny injury or conce.		1 Burial 2 Cremation 3 L 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	Removal from State	cemetery, crematory o FTRO CREY	n other place) MATOR V 10- and Address Facility,	06-06 BROWI		1170171-0
	Physician		23a. Part1. Enter the disease, or companies shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that caused the deat one cause on each line.	th. Do not enter the m	ode of dying, such as cardia	c or respiratory an	est,	Approximate Interval Between Onset and Death
	/Medical Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. PNEUMC Due to (or as a consec	NIA juence of):				9 DAYS
8760,	cate be executed physiclen and the burial-transit	lical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. <u>CBSTRUC</u> Due to (or as a conseq		eep apmed	+		YEARS
P.O. Box 6	The law requires that the death certific ate hes been signed by the ettending p page 2 should be detached for use as:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c	il déath 3 □Ectopic			23d. Date of de Month	olivery Day Year
	w requires thet been signed b should be deta	5	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	g cause given in Part I.		obacco use contribute t es 2 □ No 3 □ P	o the cause of death?
Division of Vital Records,	n: The law r ficate hes be rr. page 2 sh	Completed	Re W					sy prior to death? 2☑No 1☐Yes	utopsy findings available completion of cause of
⋚	recto	Be	25. Was case referred to medical examiner?	Hospital:		1 04	ath Check only or		
ion of	To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate hes completely illed in by the funeral director, page 2	ation; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No		lence 6 □Other (Spe ow injury occurred	ecify)
Divis	itef or Attenrs after deal	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fact fy)	ory, office	28f. Location (S City or Tow	treet and Number or R n, State)	dural Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	fedicai	one)	ysicien: To the best of my kno niner: On the basis of examina and manner stated.	ation and/or investigati	on, in my opinion, death occ	urred at the time, o	date and place, and du	e to the cause(s)
	or with the second seco	Σ	29b. Signature and title of certifier			29c. License number	1	29d. Date signed (Mon	th, Day, Year)
•			30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	RE3-500		OCTOBER	
	Sta	ote.	DR VANESSA W 31. Date filed (Month, Day, Year)	JALKER HARD 3 Règistrar's Signa	215 4940 ature	EASTERN AU	ENUE BI	alt thure,	1994 COH
	Registi		OCT 0 5 200		ature (,			

DHMH 17 Rev 1/2001

			For A				Health and M			31636
			1 - State Amend item#26, Registrar Amend #20b I	Per FH G860 10/0	3/10 /0	diffeate of	Death	2. Date of Deat	eg. No.	
п	Physici	an	1. Decedent's Name (First, Middle, Last) Saul Benison, Ph.D.					Month October	Day Yeer	3. Time of Death 6:00 A. M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. Cily, Town,	or Location of Death	oc coper	4c. County of Dea	
			Jewish Convelesant				kesville		Baltimor	
	Funeral Director		5. Social Security Number 6. Sex 120-10-1494	7. Age (In yrs.)	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day) Nov. 02,	Year) 9. Bir 1920 Bro	hplace (State or Foreign buntry) Oklyn, N.Y.
	D D		Usual Residence of Decedent					1100.02,	1720 DIC	
	ahow	5	10a. State 10b. County		y, Town or Lo MONIUM					10d. Inside City Limits 1 ☐ Yes 2 💆 No
	28a-f	rect	Maryland Baltimore	e country 11		10f. Zip Code		1	0g. Citizen of What Co	ountry?
	th with 23a or let be	Funeral Director	44 Gorsuch Road			21	.093		United Sta	tes
	tema tema	uner	Tr. Maria. Grateg	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
39	urs eft	by F	1 A Never Married 2 Marned 3 Widowed 4 Divorced	1		1 ☐ Yes 2 🛣 No	Specify:		Specify: Ty	Mhite
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121	within ane. than	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)		do not use retire Llege Pro			University Cincinnati	
1d 2	e filed within al Hygiene. I other than '	Be Co	17. Father's Name (First, Middle, Last)		000		18. Mother's Nam	e (First, Middle, I	Maiden Sumame)	
ylar	Mental Mental arked c	To B	Nathan Benison				Rose Gre			
Maryland 21215-0036	s 1 end 2 should be filed within 72 hours efter death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, ine Medical Examinar must be notified at		19a. Informant's Name/Relationship (Type Kenneth R. Berger,			ng Address <i>(Stree</i> Orsuch Ro		a <i>l Route Number</i> nium, Mā	r, City or Town, State, aryland 21	Zip Code) .093
	f Heali fram 2 other		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of matory or other pla		-	20c. Location - City or	Town, State
imo	Page: Iment of tant: If i		1 ☐ Burial 2 🖾 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Eva	ns Fur	neral Cha	pel oct.	96 , 2 00	Forest F	Hill,Maryland
Baltimore,	permit. Pages Department of I Important: If iti any Injury or o		21. Signature of Euneral Service License	f- gain	A Pe	Name and Addr Paceful A 325 York	ess of Facility Alternativ Road Ti	es Funer monium,N	al&Cremati Maryland	on Ctr.,P.A.
			23a. Parri Enter the disease or complic shock, or heart ailure List only on	cations that caused the deat	n. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory arr	est.	Approximate Interval Between Onset and Death
11	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	17/5951	ner	V 1)12	sease			Tyeurs
1	Examiner			Due to (or as a conseq	uence of):	0034	Ful	general		
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uerice of).	11	210	. No	6	
, حرد	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	neuce of).	Green	A le ci		<u> </u>	
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Вох	The law requires that the death certifica tie has been signed by the ettending ph tage 2 should be delached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d	Ideath 3	☐Ectopic pregnanc☐ Other (specify)	ру		23d. Date of de Month	livery Day Year
P.O.	that the de ed by the detached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	eau J					
	res that igned to be det	by P	Part II. Other significant conditions con	. 1 1	-		iven in Part I.		bacco use contribute t	
ord	w requir been si should l	eted	HALEROS CIEN	0 46 (013	5/110	25550	Mey	1 🗆 Y	-	robably 4 Unknown
Rec	The law sete has t page 2 s	Completed	1)150000.	10/05				24a. Was a autop: perfor	med? prior to death?	utopsy findings available completion of cause of
ital		0	25. Was case referred to medical	710000	3		26. Place of Dear			s 2□ No
χ	Physician: this certific ral director,	To B	I TI 162 STAINO	lospital: 1 Inpatient	EIVOUR	3 DUA	-		ence 6 Other (Spe	ocify)
on c	ding P. h. After i funera	tlon;	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W	uryat ork?]Yes 2∐No	28d. Describe h	ow injury occurred	
Division of Vital Records,	or Attending ifter death. Diractor: After in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st			28f. Location (S City or Tow	treet and Number or F n, State)	ural Route Number,
_	To the Hospital or Attending Is within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical Ce	(Check only 2 Medical Examin	sician: To the best of my kno ner: On the basis of examina	wledge, deat	th occurred at the	time, date and place, opinion, death occur	and due to the c	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To tha within 2 To tha comple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licer	nse number	2	9d. Date signed Mon	th, Day, Year)
	, - 0		Mule Bl	Levous	you	N	17753	5	10150	06
	4		30. Name and address of person who co	U 121 C	205	S. S.	Le 30	1.	Kesville	(Nayley)
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa	Rure	ASK.			2	1651

			ForState	State of Maryland	Department of l			711115	31637
	Physici	an	1. Decedent's Name (First, Middle, Last)	all Bu	otios		Date of Death Month Da		3. Time of Death
	/Medi Examir	cal	4a. Fapility Name (If not institution, give s	treet and number)	4b. City, Town,	or Location of Death	40	. County of Death	3.2311 **
			Hartord March 5. Social Security Number 6. Sex	7. Age (In yrs. Jasi	birthday) If Under 1 Year		Pace Date of Birth	Hart 9. Birthp	ace (State or Foreign
	Funeral Director			M 20F 85	Yrs. Months Days	Hours Min.	Month, Day, Year	920 mc	aryland
	anyland		10a. State 10b. County	10c. City, 1	own or Location			11	0d. Inside City Limits
	with the Maryland a or 28a-f ehow	Director	10e. Street and Number	ord A	10f. Zip Code		10g. Ci	tizen of What Coun	
	death with the Maryland ms 23e or 28e-1 show		633 Frans	2. Was Decedent Ever in U.S.	13 Was Decedent of	Hispanic Origin? (Speci	v Yes or No-	05H 14. Race - Americ	an Indian.
\	5 £ 5	Completed by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes Give	If Yes, specify Cut 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spectoan, Mexican, Puerto Ri Specify:	ćan, etc.)	Specify: (1)	oite
0325	within 72 hours ene. then "natural", te Modical Exe	eted b	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Educ (Specify only highest grade		6a. Decedent's Usual Occu	during most of working	16b. K	(ind of Business/Ind	dustry
22.03	within liene. r then "	omple	Elementary/Secondary (0-12)	College (1-4or 5+)	Self	Employe	d l	phols	terer
		Be	17. Father's Name (First, Middle, Last)	Rantin	5 616	18. Mother's Name (First, Middle, Maider	Sumame)	
Maryland	should and Men s marke	To	19a. Informant's Name/Relationship (Typ	Bunting (SOn)	90. Mailing Address (Stree	t and Number or Rural F	Route Number, City	or Town, State, Zip	Code)
	s 1 end 2 if Health Item 27	1	20a. Method of Disposition	unting 20b. Place	e of Disposition (Name of	lor Id.	o 20c. V	ocation - City or To	wn, State
13/06 Baltimore	00		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	More	etery, crematory or other plantand Mcmona	Hark 17	106 B	Utimore	, mo .
Pag.	pe mit. Pag Department Imcortant: I eny in ury o		21. Signature of Funeral Service License			"Filtreral Cl 3 Newport 1		d Cremo	ution Services
7			3a. Far1. Enter the disease, or complished, or heart failure. List only on Immediate Cause (Final	cause on each line.	Do not enter the mode of dy	ing, such as cardiac or i	A STATE OF THE STA	,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequer	nce of):	Yest.			
3	Examiner	ē	Sequentially list conditions if any, leading to immediate	Due to (or as a consequer	nce of):	evation 1	MI		
JXV.	secuted and I-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer	ntero Co CC h	s UTI			
8760	ate be executed hysicien and the burial-transit	dical E				Through v	9		
Box 68	eath certifice attending pr		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnanc	y	N/A		23d. Date of delive	ny
	death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown		cy //T		Month M	Day Year
۵	res thet the igned by be detact	by Ph	Part II. Other significant conditions con	stributing to death but not resulti				use contribute to th	
cord	w require been si should I	leted	COS	onay Her	ery Dires	RE	1 ☐ Yes 2		ably 4 □Unknown psy findings available npletion of cause of
John Vital Records, P.O.	The lav	Completed					autopsy performed? 1 ☐ Yes 2 ☑ No	death?	
	ysiclan: The s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	VOutpatient 3 □ DOA O	26. Place of Death (Check only one) 5 Residence	6 □Other (Specifi	v)
0)0	ding Physi h. After this o funeral dire	lon: T	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	Bb. Time of linjury Wo		d. Describe how inju		
J. J. J. C.	f or Attendi after death. Director: A I in by the f	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom- building, etc. (Specify)	e, farm, street, factory, office		f. Location (Street a City or Town, Stat		I Route Number,
30	No the Hospitel or All within 24 hours after or All to the Funeral Directompletely filled in by	al Cer	29a. Certifier 1 Certifying Phys	sicians. To the best of my knowle	edge, death secured at the t	time, date and place, an	d due to the cause(s	t) and manner as si	al so.
B	the Ho Ihin 24 I the Fu	Medical	(Check only one) 2 Medical Examination 29b. Signature and title of certifier	ner: On the basis of examination and manner stated.		opinion, death occurred		id place, and due to ate signed (Month,	
	$\left(2\right)^{3}$		• 6	Phy.	sician D		1	5.3.200	
-	57		30. Name and address of person who co		3a) (Type, Print) O OPPCY	chesepeake	Dr, B	el Air	MD 210K1
	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 0 6 2006	32. Registrar's Signatur			•		

			State of Maryland / Department of Health and M		0000	01600
_			Ragistrar Certificate of Death		19. No 2 U U b	31638
	Physici	an	1. Decedent's Name (First, Middle, Last) Dolores W. Brownson	2. Date of Deat Month	Day Year	3. Time of Death S, 299 M
	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	10 -	4c. County of Death	
	Examin		Franklin Square Hospital Center Prosedule		Baltin	nore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Feb. 3	Year) 9. Birth	
	Director		215-24-7173 1□M 2⊠F 78 Yrs. 10011 353 10013 11011	Feb.3	,1928 Mary	/land
	yland how		10a. State 10b. County 10c. City, Town or Location			10d. fnside City Limits
	Ba-1 •	Director	Md Baltimore Essex			1 ☐ Yes 🌺 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Plygiene. Important: if Item 27 is marked other then "naturel", or Iteme 23s or 28s-1 show any injury or other traumatic event, If a Medical Endish or must be indiffed at once.		10e. Street and Number 3B Glenwood Road 10f. Zip Code 21221	10	0g. Citizen of What Cou USA	ntry?
S	ame 2	Funerai	11. Maritaf Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecrity Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
0 lores 5-0036	hours after ture!; or its	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ② No Specify: Year or Dates:	, , , , , , ,	Specify: Whi	
Dolore 21215-0036	72 hour	ted t	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/In	
D ₂	within 7. ene. then "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)		Iomm P II	T
	filed wi Hygien other th		10th		Horn&Horn	inc.
own5on e, Maryland	d be fi	To Be	17. Father's Name (First, Middle, Last) William T. Wyatt Anna	e (First, Middie, N Mae Bar		
) Caryl	should and Men marka umatic	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	al Route Number,	City or Town, State, Zij	
~ .	and 2 salth e n 27 id		Shawn Brownson / son 3654 Ridgeview Roa	d Ijams	sville MI	21754
Baltimore	ges 1 t of He if iten or oth		1 Burial 2 Stremation 3 Removal from State cemetery, crematory or other place) 10 /	7/06	20c. Location - City or To	
CO ₽	it. Pages intment of intent: if i	- 8	4 Donation 5 Other (Specify)	Е	Baltimore	
Ba	permit. Depenti Import any inj once.	1 4	R Terry Cornelly, Connelly Funer		Ave. Balt	
			23a. Part 1. Enter the disease, or condition that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition Pne um on a			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			1 -
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury) b. Interstituting Disease Consequence of): Cause (Disease or injury)		7	-5 years
K	cuted	Examiner	cause. Enter Underfying Cause (Disease or injury that initiated events c.			~
0,	cate be executed obysicien and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
8760,	cate b physic the b	dicai	d .			
9 x c	eath certific ettending p for use as	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deliv	arv
. Box	death e etter	by Physician/Me	in the past 12 months? 1		Month	Day Year
0.	res that the de signed by the e i be detached t	hys	9 ☐ Unknown 9 ☐ Unknown			
Division of Vital Records, P.O.	Attending Physician: The law requires that the death certific death. sctor: Atter this certificate has been signed by the ettending to the funeral director, page 2 should be detached for use as	d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	s 2 No 3 Prol	he cause of death?
lo So	aw requir s been si 2 should	Completed		24a. Was ar	24b. Were auto	opsy findings available impletion of cause of
8	The lavele hes	E O		autops perform	ned? death?	
/ita	ician: Th certificete rector, pag	Be (25. Was case referred to medical examiner?	h (Check only one	9)	
ot	Physi this c	- T			nce 6 Other (Special	ý)
o U	Attending Pl r death. sctor: After tl by the funera	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	200. Describe no	w injury occurred	
Visi	er dea rector by th	Certification: To	3D Suicide 6D Could not be	28f. Location (Str City or Town	reet and Number or Run	al Route Number,
۵	urs eft ref Di					
	To the Hospital or Attending Physician: The law within 24 hours effor death. To the Funerel Director: Affor this certificate hes completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ca red at the time, da	use(s) and manner as s ate and place, and due t	tated. the cause(s)
	To the To the comp	ž	29b. Signature and title of contrier 29c. License number		9d. Date signed (Month,	
	1,		1 (m 1 - 1/W MD. DO0511/Q		1013,	106
	M		30. Name and address of person who completed cause ordeath (Item 23a) (Type, Print) Dr. Laura Steele 9000 Franklin Square D 31. Date filed (Month, Day, Year) OCT 0 5 2006 Registrar's Signature	Tive P	a Himore	Md 21237
	Sta	ite	31. Date filed (Month, Day, Year) 38. Registrar's Signature	1110 10	1	
	Registr	ar	OCT 0 5 2006 Steen B. Boule			

		•	For State	State of Ma	aryland .	Department / Certificate			- Z U U I	6 31639
			Registrar 1. Decedent's Name (First, Middle, L	ast)		Ochinicate	OI DOULII	2. Date of De.		3. Time of Death
	Physici /Medic		MElvin			Bun	GARdNER	Detaber	Day Yes	6 19:3x8M
)	Examin	er	4a. Fecility Name (If not institution, g	ive street and number)	bsoit.	al Bal	own, or Location of De	ath	4c. County of D	eath
	Funeral		5. Social Security Number 6.	Sex 7. Age	In yrs. last	birthday) If Under 1	Year II Under 24 H Days Hours M	rs. 8. Date of Birt	th 9.	Birthplace (State or Foreign
	Director		194-40-7700 Usual Residence of Decedent	1 ∑ M 2 □ F	53	Yrs.	Day's Hours IN	in. NOV • 1 C	7,1952 PA	Birthplace (State or Foreign Country)
	ryland how		10a. State 10b. County		10c. City, T	own or Location				10d. Inside City Limits
	Be-f	Director	PA Frank	lin		Chambe				1 ☐ Yes 2 No
	23a or 2		10e. Street and Number 5395 Greenvi	llage Roa	d	10f. Zip 0	201		10g. Citizen of What USA	Country?
036	be filed within 72 hours after deeth with the Maryland ttal Hygiene id other than "natural", or iteme 23a or 28e-f ehow event, the Medical Examinar must be incitified at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 12 Yes 2 N If Yes, Give Year or Dates:		13. Was Decede If Yes, specif	int of Hispanic Origin? y Cuban, Mexican, Pu No Specify:	(Specify Yes or No erto Rican, etc.)	- 14. Race - A Black, W Specify: 1	merican Indian, /hite, etc. Vhite
1215-0036	72 ho 'natur	eted	15. Decedent's (Specify only highest of		1	6a. Decedent's Usual (Give kind of work	Occupation done during most of interest	vorking	16b. Kind of Busine	ss/Industry
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		ibist		Aero S	pace
מפ	e filed al Hygie other vent, II	Be C	17. Father's Name (First, Middle, La.	st)				lame (First, Middle,		
Maryland 21	2 should be and Mental ie marked o aumatic eve	To I	Melvin Bumga					Louise T		
			19a. Informant's Name/Relationship Diana S. Bumga			19b. Mailing Address (5395 Gre	Street and Number or envillag			
Baltimore,	t to		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control Contr		ceme	e of Disposition (Name etery, crematory or oth 7 iew Crem	er place)	Date / 06/06	20c. Location - City Baltimon	
Balti	permit. Page Department of Important: If any njury or		21. Signature pol Funeral Service Lic	y Conn	elle	22. Name and	Address of Facility 3 Ly Funer	00 MAce	Ave.Balt	to.MD
			23a. Part1. Enter the disease, or ce shock, or heart failure. List on	mplications that caused by one cause on each lin	the death	not enter the mode	ol dying, such as card	liac or respiratory ai	rrest,	Approximate Interval Between Onset and Death
)	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)	aSA	EPSIS	and all				24 Hours
	Examiner		Sequentially list conditions			FAILURE				1 year
	g (]/ ts	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a						710 years
,	n and	Examin	that initiated events resulting in death) Last	C. Due to (or as a	a consequen					Trongens
6876 0	ficate be executed physicien and site the burial-transit	edical		d						
_		/Mec	IF FEMALE:	23c. If yes, outcome	of pregnancy	,			204 0-1-4	de la constant
P.O. Box	The law requires thet the death cert Ne has been signed by the attending page 2 should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	ath 3 Ectopic pre-			23d. Date of Month	Day Year
	w requires thet the de been signed by the a should be detached t	þ	Part II. Dither significant conditions DIAGETES	e contributing to death but MELLI TUS	ut not resultin	ng in the underlying car	use given in Part I.			e to the cause of death? Probably 4 \(\sqrt{n} \)
Vital Records,	hysician: The law re his certificete has bee il director, page 2 sho	Completed	ATHERO	SCLEROSI'S				24a. Was autop perfo	prior death	
Ita		BeC	25. Was case referred to medical examiner?				26. Place of I	1 ☐ Yes Death <i>Check</i> only o		/es 2□ No
5	Attending Physician: or death. ector: After this certifice by the funeral director, i	မ	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatie		/Outpatient 3 DOA			dence 6 Other (5	Specify)
0	Attending Ph death. ctor: After th y the funeral	atlon	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day	Year)	Injury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	Zod. Describe i	low injury occurred	
Division of	at or Attendates after death	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At home c. (Specify)	e, farm, street, lactory,	office	28l. Location (S City or Tox	Street and Number of wn, State)	r Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (29a Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination	dge death occurred at and/or investigation, i	the time, date and plin n my opinion, death or	and due to the courred at the time,	cause(s) and rianned date and place, and	r as stated. due to the cause(s)
	To the To the comp	Ž	29b. Signature and title of certifier				License number		29d. Date signed (M	onth, Day, Year)
•	2		30. Name and address of person wh	w			45044		ctober	5, 2006
			سب س بھر	o completed cause of de	eatri (Item 23	oa) (Type, Print)	St. Ball	MOLE TA	Gey Gran	21287
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 5 2006	32. Registra	ar's Signature	carle	, 7.1.1		1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #20b per anylarity beograpient of Health and Mental Hygiene

Continue of Death 31540 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 9:15 A^M MARY E. BRAUN OCTOBER 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GILCHRIST HOSPICE TOWSON Birthplace (State or Foreign Country) tf Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral 5. Social Security Number 6. Sex Min. Months Hours 1 □ M 2 🖾 F Director 06/20/1945 214-44-2783 MD Usual Residence of Decedent 10c. City, Town or Location 10d. tnside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
snt: If item 27 ie marked other then "neturel", or iteme 23e or 28a-f ehow ury or other traumatic event, the Mudical Examiliar traust be notified at 1X Yes 2 ☐ No Director BALTIMORE MD DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 817 JEANNETTE AVE 21222 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Btack, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH CUSTODIAN **FACTORY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES SITES ၉ EVELYN BRICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 JEANNETTE AVE, DUNDALK, MD ROBIN BRAUN/DAUGHTER 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of important: if it any injury or o 1 🔀 Burial 2 🛣 ⊖remation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREM/OAKLAWN | 10/11/2006 DUNDALK, MD 22. Name and Address of FacilityWESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licenses 2007-09 EASTERN AVE., BALTIMORE, MD 21231 23a. Part 1. Enter the disease, of implications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each ne. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER Physician reasi ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner inding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hospitel or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ pice After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fo the ht.
within 24 hour.
To the Funeral Dr.
letely filled in by' 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and tale of certifier

State Registrar DHMH 17 Rev 1/2001

3

31. Date filed (Month, Day, Year)/

OCT 0 6 2006

30. Name and address of person who completed cause of death (July 23a) (Type, Print)

6- Sunc

32 Registrar's Signature

E Applicate

October 3, 2006

Charles St. Balts and Zizox

			1 - For State Registrar	State	of Marylan	d / Depa <i>Cei</i>	artment rtificate	t of H e <i>of L</i>	ealth a Death	and M		ien 2 0 0	5 3	11641	
	Physici	an	1. Decedent's Name (First, Middle	,							2. Date of Deal Month	Day	rear	Time of Death	
	/Media	al	PHYLLIS BA 4a. Facility Name (If not institution	RNER	ımber)		4b. City.	Town, or	Location (October	4 200 4c. County of		06:52 ^M	
H	Examin	er	GILCHRIST NURS		HOME BALTIMORE					BALTIMORE					
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2€X F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	Country)	(State or Foreign	
	Director		432-19-8789 Usual Residence of Decedent	I I M QLA	46	Yrs.		•			SEP 14	1960	ARKAÑS	SAS	
	yland yland		10a. State 10b. County		10c. City	, Town or Lo	cation		~				10d. I	nside City Limits	
	Sa-f et	ctor	MARYLAND HAF	FORD CO		ABI	ERDEEN	1						I∏Yes ŽŽNo	
	with th	Directo	10e. Street and Number				10f. Zip				1	0g. Citizen of Wh	,		
	ne 23	Funeral	440 GRASSMERI		edent Ever in U.	S. 13.	Was Deced		1001 Ispanic Ori	ain? (Sp	ecify Yes or No-	U.S.A	American II	ndian.	
o.	after o		1 ☐ Never Married 2 Marr	Armed F ed 1 ☐ Yes	orces? 2⊠No	i	 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify: 					Black,	Black, White, etc.		
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<u>Ş</u>	nould d Men nerke netic	ို	MATHIS JOHNSON 19a. Informant's Name/Relations		144-7-44	10h Maille		(Carrott o			A LEE SM		tota 7ia Coa	4-1	
Σ	lth an		Jeffrey Barner	26		1						; <i>City or Town, S</i> altimore			
ē,	es 1 and 2 should be filed w of Heelth and Mental Hygiei filtem 27 is marked other ti ir other traumatic event, the		20a. Method of Disposition			lace of Dispo	sition (Nam	ne of	- 1	-		20c. Location - C			
Ĕ	Pages ment of ent: If it ury or o		1 XX urial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State	E VILI	•		1	10-1	4-06 I	LAKE VIL	LIAGE,	ARK.	
LAKE VILLAGE CEMETERY 10-14-06 LAKE Continue of Funeral Surfer Licensee Lake															
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28	tificate ng phy as the		IE SEMALE.												
X Q Q	death certifica le ettending ph ed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregna birth 2 Tetal	death 3	Ectopic pre					23d. Date Mont		Year	
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ecords,	w require been sig should b	ted k	asp.rn	tim	pne	JMC	nin	1			1 □ Ye	s 2 10 3	☐ Probably	4 ∐Unknown	
ပ္ဆ	hes be	Completed									24a. Was a autops	y pri	or to comple	findings available tion of cause of	
	Th ate pag								-		perform	2 No 1	ath? ☐Yes 2☐	No	
		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2 🗆	ER/Outpatier	r 3∏.DO	A Othe			n <i>Check on on</i> me 5∐ Reside	ence 6 Other	(Specify)	Dince	
	ding Phys h. After this funeral di	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date	of Injury oth, Day Year)	28b. Time of		Bc. Injury Work	at		28d. Describe ho	w injury occurred	1	Ch	
S		catle	2 Accident investig	pation			М	101	Yes 2	No					
5	after of Direction by	Certification:	4 Homicide determ	ned 286. Plac	e of Injury - At ho ling, etc. <i>(Specif</i>)	me, farm, str	eet, factory	, office			28f. Location (St City or Town	reet and Number n, State)	or Hural Ro	ute Number,	
	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To th Examiner: On the I	e best of my kno pasis of examinal	wledge, deati	n occurred a vestigation,	at the tim in my op	e, date an pinion, dea	d place, th occur	and due to the cared at the time, d	ause(s) and mani ate and place, an	ner as stated	I. cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1	27				number			9d. Date signed			
			1/1/ Parti	my Ke	ly, c	no	I)2.	520	U	(Octobe	er 4,	2006	
	Ý		30. Name and address of person	who completed cau	/ /	23a) (Type,	Print)	1. 4	hai	le,	St. 1.	October Solts	and	21204	
	Sta Registr		31. Date filed (Month, Day, Year)	7 -	ogistrar's Signa										

amend item 19a per ff 1860 10 6 106 and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 2006 5:00 AM M Fred Granville Burall 10 03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Smithcare Edgewood, Maryland Harford | Il Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Director Yrs 215-22-6889 09/02/1927 Maryland Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at MD 1 ☐ Yes 🏋 No Baltimore Hydes Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13207 Bottom Road 21082 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 💆 No þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Vice-President Equitable Bank Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 end 2 should be nent of Heelth and Mental Arthur Burall Suzie M. Story 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a Important: If item 27 is any injury or other tree 2008. S. Timothy Burall (son) 13207 Bottom Road - Hydes, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/09/2006 Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee É assaln 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between tmmediate Cause (Final disease or condition resulting in death) ALZ HET MERIS **Physician** ENETR 3 YEARS /Medical OBSTRUCTION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner MANTLE CELL LYMPHOMA burial-transit The law requires that the death certificate be executed Records, P.O. Box 68760 attending to tor use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably Completed 1 ☐ Yes 2 ☐ No. 4 DUnknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one ASSISTED Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA LIVING 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending neurs efter death. nerel Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and fitte of certifier 29d. Date signed (Month, Day, Year) 20016389 30. Name and address of person who completed cause of death (Item 23a) (Type, PERFECTO C. VALARAO, M.D. 1716 HARFORD RISU. 105 FACISTON MD 21047 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 6 2006 Registrar

06-07391 Luther Bryant

Please Type or Print in Black Indelible Ink

uther Bryant		State of Maryland / Department of Health and Mental Hygiene 1-For State Amend #1Per ME Per FHC GROUNG Begint 12/06 JH Registrar Reg. No. 2006 3	164
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last) 1. Decedent's Name (First, Middle,Last) 1. Decedent's Name (First, Middle,Last) 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day October 1, 2006 3. Time of De Cottober 1, 2006	
vieolcai Exami		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
		Johns Hopkins Hospital Baltimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Party 8D/YYYY 9. Birthplace (State Foreign Country) 11 Country 11 Country) 11 Country 11 Country 11 Country 11 Country 11 Country) 11 Country 1	or
	-	Usual Residence of Decedent	
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ie Maryland or 28a-f show fied at once.	Director	MD, Citizen of What Country?	
with the Maryland us 23a or 28a-f sho be notified at once.		3144 ELMCRA AVE. 21213 USA	
	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bla White, etc.	ack,
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36 nin 72 h shan "r dical F	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) College (1-4 or 5+) UNIT 18. Mother's Name (First, Middle, Maiden Surname)	
5-00 led with tygiens other		17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene marked other than e event, the Medica	Be	LUTHER BRYANT CAROLYN BOYD 19a. Informant's Name/Relationship (Type, Print) MOTIR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
e, MD 21215-0036 I and 2 should be filed within 72 hours after Health and Mental Hygiene item 27 is marked other than "natural", r traumatic event, the Medical Examiner.	유	19a Informant's Name/Relationship (Type, Print) MoTIR 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN BALTO, M.D. 21213 20a Method of Disposition 20b Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State)	
re, N I and FHealth Fitem	ı	2Ca Method of Disposition 2Cb. Place of Disposition (Name of cemetery, Date 2Cc. Location - City or Town, State	
Baltimore, permit Pages I ar Department of Hes Important: If ite		4 Donation 5 Other Specify: KING MEMORIAL PARK 10-9-2006 BATTIMORE, MI	0,
Baltimo permit Page Department Important:		21. Signature of Funeral Service Licensee 22. Name and Address of Facility WEATHER FORD FUNERAL SERVICE 2431 E. OLIVER ST. BACTO. MD. 21213	55 P.A.
Physician	T	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Between O	
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	niner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.	
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ox 68760, and certificate be executed attending physician and or use as the burial - transit	Medical	UNPENDED AMENDED	
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Box 687 e death certific the attending p	sician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	Year
). Bo): the deatl by the att	Phys	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of d	eath?
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Vital Rec ysician: The I his certificate I	Be	25. Was case referred to medical examiner?	
n of Vi ding Physi After this	<u>ان</u>	27. Manner of Death 28a Date of Injury 28b. Time of Injury 28c Injury at Work? 28d Describe how injury occurred	
ion (tendinesath	Certification:	1 Natural 5 Pending Oct 1, 2006 2151 hrs 1 Yes 2 ✓ No Subject shot	
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Division of Vital Records, P.O. Box 68760, To the Hospital or the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time date and along and due to the courses on started.	urnore,
o the 1 Athin 2- O the F	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
F 3 F 3	Me	29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year)	
11.		Joshe Jeef MD O.C.M.E. October 2, 2006 30. Name and address of person who completed cause of death (Item 23a)	
- 4		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
S Regis	tate	111 1 11 15 / 11110 1 8924 273 24448222 2	
Regis	шеш	400.00	1

			For State Registrar	State of Ma	ryland / Der	partment of H e rtificate of L	eaith and M Death	ientai Hygi 	ene2006	31644			
	Physici		Decedent's Name (First, Middle, L Daphne B	ast) yrne				2. Date of Death Month October	Day Year 4 2006	3. Time of Death 10:35 pm			
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)			Location of Death	000000	4c. County of Deat				
Ī	Funeral Director		Gilchrist 5. Social Security Number 105–18–3129 6.	Sex 7. Age	(In yrs. last birthda 82 Yrs.	TOWSON If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 23	Baltimo Year) 9. Bin 1924 Pe	re hplace (State or Foreign buntry) ennsylvania			
	faryland ed al	or	Usual Residence of Decedent 10a. State 10b. County Md. Balti	more	10c. City, Town or Timoni					10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	with the N 3a or 28a-f	Funeral Director	10e. Street and Number 12000 Tralee Ro		1 21110111	10f. Zip Code 21 093		10	og. Citizen of What Co	puntry?			
220	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural; or tieme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 反 N If Yes, Give Year or Dates:	o los.	3. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit				
N-017	vithin 72 hou ne. han "nature n Medical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4or 5-	F3	cedent's Usual Occupa ve kind of work done of DO NOT use retired ICIPAL SECT		ing	16b. Kind of Business/				
and z	e filed v al Hygie I other ti vent, th	Be Co	17. Father's Name (First, Middle, La.	+2 st)		crhai seci	18. Mother's Name	e (First, Middle, M		л і			
<u> </u>	hould b d Ments marked matic e	To	Theodore Douk 19a. Informant's Name/Relationship		19h Ma	iling Address (Street a	Marian		te City or Town, State, 2	Zin Code)			
Z Z	and 2 salth an n 27 le i		Mrs. Valerie Ros		60	Stoneway F	Place Not	tingham,	Md. 21236				
Поге	Pages 1. ent of He nt: If Iten ry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of	Removal from State	1_	position (Name of rematory or other place Valley Men			20c. Location - City or Timonium ,				
Dalillo	permit. I Departm Importar any Injur		21. Signature of Funer I Service Lic		Duraney	22. Name and Addres	s of Facility	al Home.	Inc.				
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neco	The law receive has been page 2 sho	Completed	′ /					24a. Was ar autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of 2 \(\text{\subset} \) No			
VISION OF VITAL	To the Hospital or Attending Physician: The law requires that the death cen within 24 hours efter death. Within 24 hours efter death. To the Learneral Director After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Certification: To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 □ Pending investigat	28a. Date of Injury (Month, Day	nt 2 ER/Outpat y Year) 28b. Time Injury	of 28c. Injury	4 🗀 Nul Sing 110		nce 6 Other (Spe	city) Hospice			
<u> </u>	al or Atte s efter de al Directe ad in by ti	Sertific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, farm, . (Specify)	street, factory, office		28f. Location (Str City or Town	eet and Number or Ru , State)	ural Route Number,			
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	To the within To the comp	Me	29b. Signature and title of cartifier	Z V	Can un	29c. License			od. Date signed (Mont				
	10		30. Name and address of person wh	o completed cause of de		e, Print) V. Charl	Ces St. 1	falto	md Zi	20%			
Ī	Sta Registr		31. Date filed (Month, Day, Year)		r's Signature	Soull 1							

		4	For State Registrar	State of	Marylan		artment rtificate			and M	ental Hy	giene	006	316	45
	Physici	an	1. Decedent's Name (First, Middle	a, Last)							2. Date of De. Month October		2006 ^{Yea}	3. Time o	
	/Medic	al	Helen R. Beutel		h - al		4h Cib. T		l anntina a	4 Death	Uctober		ZUU6 County of De	7:20	Рм
/	Examin	er	4a. Facility Name (If not institution Upper Chesapeak				46. City, T		Location	or Death			rford	aun	
	Funeral		5. Social Security Number	6. Sex 7	7. Age (In yrs.	last birthday)	If Under 1	Year	If Under		8. Date of Birt	h	9.6	Birthplace (State Country)	or Foreign
	Director		086-36-7703	1□M 2∏F	59	Yrs.	Months	Days	Hours	Min.	NOV. 9	194	16	Nev	York
	bug w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	ity Limits
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	r 28s	irec	10e. Street and Number		1011	y man	10f. Zip (Code				10g. Citiz	en of What		
	23a o	Funeral Director	4015 Pinedale D	rive			2123	36			l	JSA			
	tems tems	uner	11. Marital Status	12. Was Deced	ces?	S. 13.	Was Decede If Yes, specif	nt of Hi	spanic Ori	gin? (Spe 1, Puerto	cify Yes or No Rican, etc.)	. 1	4. Race - Al Black, W	merican Indian, hite, etc.	
36	rs afte	by F	1 Never Married 2 Mari	ied 1 ☐ Yes If Yes, Give Year or Da			1□ Yes 2	X No	Specify:			ļ	Specify:	white	
21215-0036	within 72 hours after deeth with the Maryland ene. Than "naturel", or Items 23s or 28s-f ehow he Moulcal Exertifier main be inclified at	ted	15. Deceden	t's Education		16a. Deced	dent's Usual	Occupa	ation	A - 4		16b. Kir	nd of Busine		
2	thin 7	Completed	(Specify only nighe: Elementary/Secondary (0-12)	st grade completed) College (1-	4or 5+)	life. i	kind of work DO NOT use	retired)	,	t of worki	ng				
2	lygien her th	Co		(ast)		Fleme	ntary	rea		de Nome	(First, Middle,		cation		
Maryland	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelih and Mental Hygiene. Department if them 27 is marked other than "naturel; or items 23a or 28a-f show eny injury or other traumatic event, the Modical Exacultar trains be notified at once.	Be c	17. Father's Name (First, Middle, Lawson L. Finge						Ruby			Malden :	Sumame)		
<u>Z</u>	shoul nd Me mark	To	19a. Informant's Name/Relations			19b. Mailir	ng Address (l Route Numbe	r, City or	Town, State	a, Zip Code)	
ž	and 2 selth a n 27 la		Rev. Donald R.	Beutel / h	usband	4015	Pined	dale	Driv	/e; P	erry Ha	all,	MD 21	236	
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □ Removal from S	1 0	lace of Dispo emetery, crer	natory or oth	e of her place	e)	C	ate	20c. Loc	cation · City	or Town, State	
Ĕ	Peg tment tant:		4 Donation 5 Other (S	pecify)	St.	Michae				0/7/0	06		y Hal		
Ba	Depar Depar Impor eny in		21. Signature of Furreral Sarvice	Liosoffe	20		2. Name and UCK TO				Homo			rk Road MD 2120	1/1
			23a. Part1. Enter the disease, or	complications that ca	used the death								W3011,	Approxima	te
	Physician	20	shock, or heart failure. List Immediate Cause (Final	only one cause of ea	ich line.	hathmi								Interval Be Onset and	Death
20	/Medical		disease or condition resulting in death)	a	or as a conseq	1								1 941101	٠.
	Examiner		Sequentially list conditions,	b. My	yorknic o	dystro	phy							50 year	4
	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a consequ	uence of):	0								
73.	xecut	xarr	that initiated events resulting in death) Last	c. Due to (c	or as a consequ	uence of):							-	+	
8760,	Physicien: The law requires that the death certificate be executed this certificate has been signed by the ettending physicien and rat director, page 2 should be detached for use as the burial-transit	ical E		d											
68	rtificat ng phy as th		IF FCMALC.												
Box 6	ath ce tendii or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		rth 2 ☐ Feta	Ideath 3	Ectopic pre					2	3d. Date of o		Year
P.O.	the e	ysici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregna 9□Unkno	ant at time of down	eath 5	Other (spe	crfy)					11101111	24,	
مَ	es that the death certific igned by the ettending p be detached for use as	y Ph	Part II. Other significant condition	ons contributing to de	ath but not res	ulting in the u	nderlying car	use give	en in Part I.		23e. Did t	obacco u	se contribute	to the cause of	death?
rds	quires n sign uld be	ed by									10	res 2 [30	Probably 4 🗆	Unknown
Records,	law requir es been si 2 should	Completed									24a. Was		24b. Were	autopsy findings o completion of	available
æ	The lavele hes	mo.										rmed?	death	?	2039 01
/ita	Physician: The l this certificete he al director, page	Be	25. Was case referred to medica examiner?				-	1 04-		of Death	(Check only o	ne)		- 84	
o	Physic this c rat dir	<u>۲</u>	1 102 Yes 2 □ No 27. Manner of Death			ER/Outpatier 28b. Time of			7		me 5 ☐ Resident			pecify)	
o	Attending or death. ector: After by the fune	ition	1 Matural 5 ☐ Pendir 2 ☐ Accident investi		n, Day Year)	Injury	м	c. Injury Work	(? Yes 2 □		200. 2000.120		00001100		
Division of Vital	I or Attend after death Director: /	Certification;	3 Suicide 6 Could 4 Homicide determ	ined 288. Place	of Injury - At ho g, etc. (Specif	ome, farm, str	reet, factory,	office			28f. Location (: City or Tox			Rural Route Nur	nber,
Ö	Ital or rs afte el Dir led in	Cert													
	To the Hospital or Attending Is within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifyir (Check only one)	g Physician: To the Examiner: On the ba and mann	sis of examina	wiedge, deatl tion and/or in	h occurred a vestigation, i	t the tim	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and manner place, and c	as stated. iue to the cause(s)
	within 2 To the comple	Med	29b. Signature and title of certifie		er stated.		29c.	License	number			29d. Date	signed (Mo	onth, Day, Year)	
?	⊢ ≱ ⊨ ŏ		> Nigoul 1 C	Amus			Î)(x:	187	7,8	6	Bato	be 4.	2006	
	6		30 Name and address of person		1	23a) (Type,	Print)	m	B14	/	ns/ 0. 10	1 n	6 121-	2006	6
			31. Date filed (Month, Day, Year)	-1 01	egistrar's Signa		1 Gary	well	שטעוע	1	Cree 6	P - 1-90]	100	, -10,	(-
	Sta Registi	_	OCT 0 6	2006	Spara A		sele)								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** BLANEY OCTOBER :25 PM EDWARD 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** JOHN'S HOPKINS BAYVIEW CARE CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1918 BALTIMONE 7. Age (In yrs. last birthday) 87 Yrs. Birthplace (State or Foreign Country)
 Mary land 5. Social Security Number **Funeral** 1 MM 2 □ F 216-05-0173 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or Items 23e or 28a-f show the Medical Examinat must be notified at N/A Baltimore Yes 2 No Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3702 Fait Ave. 21224 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White δ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Milk Man/ Delivery Greenspring Dairy permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked oth any injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Blanev Lorenzo Laura Ayres 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Nancy M. Bradley/ Niece 2701 Golf Court Baldwin, Md. 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Coremation 3 Removal from State Hilltop Service Co. 10-5-06 Towson, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen ^{22. Na}Ruck ^{Addrass} Son Hy Fureral Home, 1050 York Rd. Towson, Md. a e, complica t only one 23a. Part1. Enter the disea e, shock, or heart fairre. complication that mused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one passe on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MESOTHELLOMA YEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HEART FAILURE 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed EMPHUSEMA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an rmed? 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27, Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Director: / investigation 3 T Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0064395 OCTOBER es of person who completed cause of death (Item 23a) (Type, Print) DANIEUE J. DOBERMAN. MD 5505 HOPKINS BAYVIEW CIRCLE, BALTIMORE, MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 0 6 2006 mells

DHMH 17 Rev 1/2001

ORIGINAL

		4	For State	State of Marylan	d / Department of H Certificate of			ne N2006	31647
			Registrar	1	Certificate of		Reg. Date of Death	Noc. C C C	3. Time of Death
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last DONALD		I+GATE		Month	26, 2006	
	Examin		4a. Facility Name (If not institution, give	street and number)		r Location of Death	,	4c. County of Death	
			NORTHWEST	HOSPITAL		ALLITOWN		BALTI	
	Funeral		5. Social Security Number 6. Se	GM OFF	Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Ye	9. Birth Cou	nplace (State or Foreign untry)
	Director		216-40-3548 Usual Residence of Decedent	6	65 Yrs.		August 16,	1941	Maryland
	land It	 ~	10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	Mary -1 sh	ţo	Maryland Bal	timore		Granite			1 □ Yes 2 No
	r 28s	Irec	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Co	untry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Items 23a or 28a-f show Important: If Item 27 is marked other than "natural, or Items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examiner must be notified at ance.	by Funeral Director	3623 Granite Rd.			21163		U.S	S.A
	deat	ner	11. Marital Status	12. Was Decedent Ever in U	.S. 13. Was Decedent of H	lispanic Origin? (Specif an, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Amer Black, White	
9	or h	F	1 Never Married 2 Married	1 Yes 2 No	- ~	Specify:		Specify:	White
21215-0036	Jral',	d b	3 SWidowed 4 Divorced	Year or Dates:	1 Yes 2 No		10	b. Kind of Business/l	
Ϋ́	"nat	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	16a. Decedent's Usual Dccup (Give kind of work done life. DO NOT use retire	during most of working	10		forcement
7	withir ane. than	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		lice Officer		Law En	lorcement
2	Hygir ther int,	ပိ	12 17. Father's Name (First, Middle, Last)		, , ,	18. Mother's Name (F	First, Middle, Ma	iden Surname)	
an	d be	To Be	Richard	C. Bathgate			Man	y Louman	
<u></u>	mark matt	۲	19a. Informant's Name/Relationship (7		19b. Mailing Address (Street	and Number or Rural F			Zip Code)
Maryland	ith ar ith ar 27 is r trau		Ms. Katherine Bathua		1006 Boxwoo	od Dr. Hampstea	id, Maryland	d 21064	
ē,	Hea tem tem	1	20a. Melhod of Disposition	20b. I	Place of Disposition (Name of cemetery, crematory or other pla	Dat	e 20	c. Location - City or	Town, State
30	Page: ent of tr: If I		1 ABurial 2 ☐ Cremation 3 ☐ 4 Donation 5 ☐ Other (Specify	Removal from State	St. John's Cemet	10/01	2/2006	Ellicott	City, MD
Baltimore,	artm ortar Inju		31. Signature of Funeral Service Licen		22. Name and Addre		- i		
ä	P G F F G	1	Membellen L	le Maos 3	Slack	Funeral Home, I Old Columbia Fi	P.A. ka Ellicott C	Tity 14D 21D43	
			23a. Part1. Enter the disease, or composition of shock, or heart failure. List only	lications that caused the dea		ng, such as cardiac or r	espiratory arrest	J., 1010 210 1	Approximate Interval Between
	Physician	-	Immediate Cause (Final disease or condition	-	and many ania	_			Donset and Death
	/Medical		esulting in death)	Due to (or as a consec	quence of):				
	Examiner		Concentially list conditions	b resp	quence of):	•			hours
	= 1/9	ner	S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co sec	quence o				
	and Ind	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c			_		
Ö,	Sien a		resulting in dealiny cust	Due to (or as a consec	quanca or).				
8760,	ficate be executed physicien and (dica		d					
9 ×	death certificate be executed to attending physicien and to a for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, outcome of pregn	ancy			23d. Date of del	ivery
Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fet: 4 ☐ Pregnant at time of	al death 3 □Ectopic pregnanc	Ey		Month	Day Year
P.O.	y the diched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown					
	n requires that the de been signed by the should be detached		Part II. Other significant conditions of	ontributing to death but not re-	sulting in the underlying cause g	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds.	uires n sign	d by					1 ☐ Yes	2 □ No 3 □ Pr	robably 4 Unknown
00		Completed					24a. Was an	24b. Were au	utopsy findings available
Re	The lar	E C					autopsy performe	ed? death?	completion of cause of
of Vital Records,		Ö	25. Was case referred to medical			26. Place of Death (1 - /		72.10
>		0 8	examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 Npatient 2 D	ER/Outpatient 3 DOA O	ther: 4 - Nursing Home			cify)
0		n; T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Inju		d. Describe how		
10	Attending I r death. ector: After by the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	, ,]Yes 2 □ No			
Division	l or Attend after death Director: A	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, street, factory, office	28	If. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Ce		1					
	e Hospital 24 hours a E Funeral letely filled	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin	owledge, death occurred at the tation and/or investigation, in my	time, date and place, an opinion, death occurred	id due to the cau d at the time, dat	ise(s) and manner as e and place, and due	s stated. e to the cause(s)
	To the Hospital within 24 hours a To the Funeral completely filled	led	one)	and manner stated.	30o Ligar	nse number	100	d. Date signed (Mont	th Day Year)
	T with CO	Σ	29b. Signature and title of certifier				250	. Date signed (Men	, 549, 1041)
			Chrom	mo		0059736		Siptensia	26,2000
1	1-1		30. Name and address of person who			1250,7	5401	ous Cou	IRT ROAD
Ç	7		31. Date filed (Month, Day, Year)	32. Registrar's Sign		FOSPITAL	J TU(000	// 2/10
		ate		100	6 4				
	Regist	rar	AAT A A A	UUC I SE	And And And And And And And And And And				
DH	Regist		OCT 0 6 2	006	to figure !				

		1	For State Ragistrar	State of Maryland /	Department of Health an Certificate of Death	d Mental Hygien	7111b 31648
	Physici /Medic	an al	1. Decedent's Name (First, Middle, Last) Last Way C Last Racility Name (If not institution, give st	reet and number)	Cummings 11	1 October	year 3. Time of Death 3. To See The Se
	Examin Funeral Director	61	The Johns H	M 2 F 7. Age (In yrs. last b	DIK DOLL W	970	9. Birthplace (State or Foreign Country) Bath Mole, MA
	Maryland		10a. State 10b. County	OLE 10c. City, To	BACTIMARE		10d. Inside City Limits 1 ☐ Yes 2 1 100
;	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene have the state of	Funeral Director	10e. Street and Number 2521 Winds	2. Was Decedent Ever in U.S. Amjed Forces?	10f. Zip Code 2/3 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F		Citizen of What Country? USA 14. Race - American Indian,
215-0036	nours after or ural', or iter	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 A Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Black, White, etc. Specify: White
LÓ I	filed within 72 Hygiene. Hygiene. ther than "nation", it a Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	Kind of Business/Industry
Maryland	hould be file d Mentai Hy marked oth matic event	To Be	17. Father's Name (First, Middle, Last) Column G. (1942) 19a. Informant's Name/Relationship (Type)	ummings	TR 18. Mother's 3b. Mailing Address (Street and Number of	Name (First, Middle, Maide	Krausz
-	ies 1 and 2 sho of Health and if item 27 is m or other traum		20a. Method of Disposition 1 Burial 2 Ocemation 3 Re	Junner 1	of Disposition (Name of leap-crematory or ether place)	Rd Jarret	Location - City or Town, State
Baltimore	permit. Pages Department of Importent: if it any injury or once.		4 Donation 9 Other (Specify) 21. Signature of Funeral Service License	- h Clenu	22. Name and Address of Facility 3. New port	10/5/06 to	0 Kest HII, MI) D 21050 Lion Services-Boldin
Į	nysician	Q 10	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition		_		Approximate Interval Between Onset and Death
74	/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or as a consequence	e of): The contract of the con	ACTO: CITTO	Tolays
	ite be executed lysician and ne burial-transit	Ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ny edema		7 days
	The law re juries that the death certificate ate has been signed by the attending physocole 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \)	Bc. If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 9□Unknown			23d. Date of delivery Month Day Year
ds, P.	uires that t signed by	d by Ph	Part II. Other significant conditions con	tributing to death but not resulting			2 No 3 Probably 4 Unknown
I Reco		Completed by				24a. Was an autopsy performed 1 Yes 2 X	
Vita	icien: certific rector.	Be	25. Was case referred to medical examiner?	ospital:	Other	Death (Check only one)	
ō	g Phys er this eral dii	n: To	27. Manner of Death	1 Inpatient 2 EHV	Outpatient 3 DOA 4 Nurs Do. Time of linjury at Work?	ing Home 5 Residence 28d. Describe how in	
Division of Vital Records,	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	1 XNatural 2 Accident 3 Suicide 4 Homicide 1 X Pending investigation 6 Could not be determined		M 1 Yes 2 No farm, street, factory, office		and Number or Rural Route Number, ate)
2)	Hospital 24 hours a Funeral etely filled	Medical C	29a. Certifier 1 Cartifying Physical Check only one) 1 Cartifying Physical Examination (Check only one)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death occurred at the time, date and and/or investigation, in my opinion, death	place, and due to the cause occurred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	1. a Va	29c. License number		Date signed (Month, Day, Year)
	V11		30. Name and address of p son who co	mpleted cause of death (Item 23a)	100	tober 3, 2006
	511		V 11 Gadrieva	1,000 01 1	1. 1. ila Charl	Baltimore A	UD 21287
	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 0 6 2006	32. Registrar's Signature			

Please Type or Print in Black Indelible Ink

anne	ela Collins		State of Maryland / Department of Certificate of			200	3 164
	Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month	Dav Year	3. Time of Death
/ledi	ical Exami		Pamela Collins	b. City, Town, or Location of Death	October 1,	2006 4c. County of Death	2233 hrs
			4a. Facility Name (if not institution, give street and number) Sinai Hospital	Baltimore		4c. County of Death	1h
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. Birtl	pplace (State or
	Director		2,57-23-432/ 1 M 2 F 46 Yrs.	Months Days Hours Min	Here ost	19,/96A Foreign	ntry) GA
			Usual Residence of Decedent			· · · · · · · · · · · · · · · · · · ·	10d Inside City Limits
	ow an		10a. State 10b. County 10c. City, Town or Location	4			1 Yes 2 No
	Maryland 28a-f show any d at once.	Director	GA Chatman Savann 10e. Street and Number	10f. Zip Code	100	g. Citizen of What Coun	try?
	the Ma a or 28 iffied a	Öire	924 East Anderson St.	31401		125 H	
	with ms 23s	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (Sp.s., specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,
	r death or ite	Funeral	1 Yes 2 No	Yes 2 No specify:	,		lack.
	irs afte tural"	ğ	or Dates:	s Usual Occupation (Give kind of w	ork done	16b. Kind of Business/Ir	
	72 hou n "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	st of working life. DO NOT use retir	,	6	
	0036 within ene er tha Medic	E E	1249 14	OUSEWIFE 18.Mother's Name	(E:	Sell	5
	D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f sho raife event, the Medical Examiner must be notified at once.		, , , , , , , , , , , , , , , , , , , ,			Bowles	-
	212 212 Muld be Menta mark c even			Address (Street and Number or R	ural Route Numb	per, City or Town, State,	Zip Code)
2	Tore, MD 2121 ages I and 2 should be fi nt of Health and Mental t: If item 27 is marked other traumatic event,		Bertha Martin / mother 924 20a. Method of Disposition 20b. Place of Disposit	East Anders	on St.	Savannah	GA 3140
	of Hea			or place)			I
	Baltimore, bermit Pages I ar Department of Her Important: If ite		4 Donation 5 Other Specify: Oak Gv	ove (on 10-	7 - 2006	Savanna	h,GA
	Baltimo permit Page Department Important: injury or ot		21. Signature of Funeral Servi / e Lice/see	ove con 10- ame and Address of Facility Harips Close 5126 Belayx	Funera	1 Sewice	P-4.
	Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	e mode of dying, such as cardiac or	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
	/Medical xaminer		failure. List only one cause on each line Immediate Cause (Final disease a. Intracerebral Hemorrhae				Death
	, Adminion		or condition resulting in death) Due to (or as a consequence of):				
		ᇦ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	_	Examiner	cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
	outed nd transit		d.	 			
	60, ate be executed physician and re burial - transit	Physician/Medical	X UNPENDED AMENDED #23a,PII,27, perME	E,g860, 10/24/06 TT			
	3760, ficate be g physici s the buri	/Me	IF FEMALE: 23b. Was decedent pregnant in the 2 Secret 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fet	al death 3 Ectopic pregna	ncv	23d. Date of delivery Month D	ay Year
	Box 6876 e death certificate the attending phy ed for use as the l	icial	past 12 months? 4 Pregnant at time of death 5 Oth	ner (Specify)	,		,
	Bo he dea' the a' hed fo	hys	1 Yes 2 No 9 ✓ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I	23e Did tok	pacco use contribute to	he cause of death?
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the sts after death and Director: After this certificate has been signed by the funeral director, page 2 should be detachled in by the funeral director, page 2 should be detach		Hypertension; cocaine use	nderlying cause given in a are i.	1 Yes		ably 4 🗸 Unknown
	ords, w require is been si should b	ete	, <u>, , , , , , , , , , , , , , , , , , </u>		24a Was a		opsy findings available ompletion of cause of
	Recor The law icate has I	Completed by			perform	med? death?	
	tal Rection: The certificate ector, page	Be Co	25. Was case referred to medical	26.Place of Death (Check			
	Vital F hysician: this certifi	To B	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient			Residence 6 Other	
	ding Pt		27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Ir	njury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
	Atten Atten Er deatl ector: by the	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, stree		28f. Location (S	treet and Number or Ru	al Route Number, City
	Division Hospital or Attended to the death fours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, St	ate)	
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death within 24 butus after death To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur				
	To the He within 24 To the Fu	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.	29c License number	it the time, date a	and place, and due to the 29d Date signed (Mo)	
•		2	29b. Signature and title of certifier	O.C.M.E.		October 3, 2006	m, bay, rear/
			30, Name and address of person who completed cause of death (Item 23a)				
			Pamela E. Southall, MD Assistant Medical Examiner 11	1 Penn Street, Baltimore, M	/ID 21201		
		tate	31. Date filed (Month, Day, Year) 2006 32. Fegistrar's Signature	uli			

			- For Amend item#15, pe	State of Maryland rFH, #30, perDVR,	/ Departme g860 0/6/ Certifica	nt of Health an ite of Death	nd Mental Hyg	gienez 006 Reg. No.	31650
)	Physici /Medio Examir	an cal	1. 1	ctreet and number)		y, Town, or Location of I	2. Date of Dea	Day Year	
	Funeral Director		5. Social Security Number 6. Se	M 2⊠F 81		ler 1 Year If Under 24 s Days Hours	Hrs. 8. Date of Birt (Month, Da) 10/18/	h 9. Bir	thplace (State or Foreign ountry) NC 10d. Inside City Limits
	or 28a-f eho	Director	MD KENT 10e. Street and Number	CHES	STERTOWN 10f.	Zip C <i>o</i> de		10g. Citizen of What Co	1 ⊠Yes 2 □ No ountry?
036	n 72 nours atter death with the maryland "nature!", or items 23a or 28a-f ehow colical Examinar must be notified at	by Funeral	25255 CROMWELL CL 11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	ARK RD. 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Dec If Yes, s	1620 Dedent of Hispanic Origin Decify Cuban, Mexican, F 2⊠ No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	USA 14. Race - Ame Black, Whith Specify: WF	te, etc.
21215	yene. rthen "nai the Medic	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 10th #TH	cation e completed) College (1-4or 5+)	16a. Decedent's U: (Give kind of life. DO NOT	work done during most o use retired)		16b. Kind of Business BENDIX	/Industry
yland	z should be filled and Mental Hyg ie marked othe aumatic event,	To Be (17. Father's Name (First, Middle, Last) CURLEY CHAVIS 19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Addre		S Name (First, Middle, LEE LOWER) or Rural Route Numbe	Υ	Zip Code)
imore,	permit. Pages 1 and 2.3 Department of Health ar Important: If item 27 is any njury or other traugues.		JAMES CURTIS/SON 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ If 4 □ Donation 5 □ Other (Specify, 21. Signature of Fundal Synice Lies	20b. Plac cerr BAY	ce of Disposition (Anetery, crematory of VIEW CREI 22. Name	r other place) MATORY 10	Date 0/07/2006 WESLEY CH	HESTERTOWN, 25500 O'CON BALTIMORE, AVIS, JR. F	NELL ST. MD 21224 NRL. HM.
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or composition shock, or heart failure. List drip of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	ications that caused the death. ne cause on each line. a	Do not enter the m				Approximate Interval Between Onset and Death
c 68760, ^C	The law requires that the death certificate be executed tie has been signed by the ettending physician and sage 2 should be detached for use as the burial-transit	licai	that initiated events resulting in death) Last	Due to (or as a onsequent	nce of):	ion liver	n insult	sciency	3 Mss
.O. Box	it the death certification by the ettending pheached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal di 4 ☐ Pregnant at time of deal 9 ☐ Unknown	eath 3 Ectopic			23d. Date <i>o</i> f de M <i>o</i> nth	livery Day Year
of Vital Records, P.	aw requires tha is been signed I 2 should be det	Completed by P	Part II. Other significant conditions co		ing in the underlying	g cause given in Part I.	1 □ \		o the cause of death? robably 4 Unknown utopsy findings available completion of cause of
		Be	25. Was case referred to medical examiner?	Hospital:			1 ☐ Yes f Death (Check only o	rmed? death? 2 No 1 Yes	s ŽD No
sion of	Attending Physician: It death. ector: After this certific. by the funeral director.	ation; To	27. Manner of Death Natural 5 Pending investigation	Hospital: Inpatient 2 ☐ EF 28a. Date of injury (Month, Day Year)	8b. Time of Injury	28c. Injury at Work?	28d. Describe h	dence 6 ⊡Other (Spenow injury occurred	əcify)
Division	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely tilled in by the	al Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)			City or Tov		
	To the Hospital or within 24 hours afte To the Funeral Direction Completely tilled in the Comple	Medical		ner: On the basis of examinatio and manner stated.	n and/or investigati	on, in my opinion, death	occurred at the time,	date and place, and du 29d. Date signed (Mon	e to the cause(s)
•	2		30. Name and thess of person who co	ompleted cause of death (Item 2		D5173	55	16/41	02
	Sta Regist	ate rar	Frederick William Del 31. Date filed (Month, Day, Year) 007 0 6 2	boy Chester River 32. Registrar's Signatur	10. 8		7/37		

		1	For State Registrar	State o	f Marylan		rtment of H			giene 0	06	31651
H	Physicia		1. Decedent's Name (First, Middle	Last)		(hester		2. Date of De. Month	Day	Year	3. Time of Death
	/Medic	al	Margaret 4a. Facility Name (If not institution)	give street and nu	mber)		4b. City, Town, or	Location of Death			ty of Deat	
	Examili		Johns Hopkins Ba	yview Me	dical Cen			nore, Ci	,			
I	Funeral Director		5. Social Security Number 212–30–6247	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 7 2		If Under 1 Year Months Days	Hours Min.	8. Date of Bird (Month, Da October	6, 1933	Co	nplace (State or Foreign untry) nsylvania
	<u> </u>		Usual Residence of Decedent 10a. State 10b. County		10c Cit	v. Town or Lo	cation					10d. Inside City Limits
	Maryla fehov	Į		imore		Edgen						1 ☐ Yes 2 No
	ith the	Olrec	10e. Street and Number				10f. Zip Code	1010		10g. Citizen o		untry?
	eath w	Funeral Directo	2919 Wells Aven		edent Ever in U	.S. 13. \		1219 lispanic Origin? (S	pecify Yes or No			rican Indian,
350	be filed within 72 hours after death with the Maryland at bygiene. A bygiene of other then "natural", or iteme 23s or 28s-f show event, the Medical Examinar must be notified at	by Fun	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	rces? 2 M No		Vas Decedent of H f Yes, specify Cuba I□Yes 2X No	Specify:	o Rican, etc.)	1	lack, White cify: Wh	· ·
9500-612	72 hou	Completed	15. Decedent (Specify only highes			(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	rking	16b. Kind of	Business/	Industry
717	within piene. r then	omp	Elementary/Secondary (0-12) 12 years	College (1-4or 5+)		Officer	.,		Bank	,_	
na	l be filed ntal Hygi ed other event, L	Be	17. Father's Name (First, Middle,					18. Mother's Nan	ne <i>(First, Middl</i> e et Stuar			
Maryland		은	Robert R. Morel			19b. Mailir	ng Address (Street					Zip Code)
	is 1 and 2 should of Heelth and Men Item 27 is marke other traumatic		Benjamin Cheste				Wells A	venue, E	dgemere,			
altimore,	Pages 1 nent of He int: if iten iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State	cemetery, crer	sition (Name of matory or other place) of Faith		ober 2006	20c. Location Roseda		Town, State Jaryland
Balti	permit. Pages Department of h important: if its any injury or of once.		21. Signature of Funeral Service	Licensee COV	rnel	ly ?	Name and Addre Connelly 1110 Soll	ss of Facility Funeral I ers Point	Home Of t Road,	Dundall Dundal	k,P.A k,MD.	21222
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat each line.	th. Do not ent	er the mode of dyir	ng, such as cardiad	or respiratory a	rrest,		Approximate interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Sep	(or as a consec	mence of/:						Four days
đ	Examiner		Sequentially list conditions,	b	(6) 45 4 55/1550							
	ted 1st	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	uence of):						
o,	death certificate be executed e attending physician and of for use as the burial-transit		that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):						
68760,	physics the bu	dical		d.								
	leath certifical attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		itcome of pregni	ancy al death 3 [Ectopic pregnanc	v			Date of de Month	livery Day Year
.O. Box	he dea r the att	ysici	in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	4□Preg 9□Unkr	nant at time of o	death 5	Other (specify)					July 102
۵.	The law requires that the de ste has been signed by the page 2 should be detached	2	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.		tobacco use co		o the cause of death?
Records,		Completed							24a. Was			utopsy findings available completion of cause of
E Be	Physicion: The lav rthis certificete has ral director, page 2 a	Com								ormed? 2007No	death?	2 No
Zita Zita	sicien certifi irector	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hocostal	Inpatient 2] ER/Outpatie	at 3 DOA Ott		ath <i>(Check only</i> Home 5 ☐ Res		Other (Soe	ncify)
Division of Vital	Attending Physicien: r death. ector: After this certifice by the funeral director, t	on; To	27. Manner of Death 1 Natural 5 Pendir	28a. Date	of Injury oth, Day Year)	28b. Time of	f 28c. Inju Wo	ry at rk?	28d. Describe			
isio	death. ctor: A y the fu	Certification;	2 Accident investi 3 Suicide 6 Could	not be 28e. Place	e of Injury - At h	nome, farm, st	M 1 reet, factory, office	Yes 2 □No	28f. Location	Street and Nu	mber or A	ural Route Number,
<u>S</u>	를 를 들		4 Homicide	Dulk	ding, etc. (Speci			-		wn, State)		
	e Hospital 24 hours a e Funaral i letely filled	Medicai	29a. Certifier 15★ Certifyii (Check only 2 Medical one)	ng Physician: To th Examiner: On the and ma	e best of my kn basis of examin nner stated.	owledge, deal ation and/or in	th occurred at the ti vestigation, in my	me, date and place opinion, death occ	e, and due to the urred at the time	date and place	manner a e, and du	s stated. e to the cause(s)
	To the	×	29b. Signature and title of certifie	M M	edical	Doctor	29c. Licen:	se number		_		th, Day, Year)
1	1		30. Name and address of person	who completed cau	use of death (Ite	m 23a) (Type	Print)					2006
-	<u>y</u>		Michael Fradley	Johns Hopk	ins Bayvie	w Medica	denter 4	940 Easte	rn Avenu	e Baltin	pore 1	daryland 21224
	St Regist	ate trar	31. Date filed (Month, Day, Year,	32. 5 2006	mayistrar s Sign	5 19	one					

		•	For State Registrar	State of Maryland	d / Depa <i>Cer</i>	artment of H	ealth an Death	d Mental Hyg	iene 006	31652
	Physicia	an	Decedent's Name (First, Middle, Last) Mari	o Cardil	10			2. Date of Death Month October	Day Year	3. Time of Death 8:05 A M
	/Medic Examin		11d r 4a. Facility Name (If not institution, give s		10	4b. City, Town, or	Location of D		4c. County of Dea	
L			210 N. Main Stree			Bel Ai		Hea La	Harford	
	Funeral Director		5. Social Security Number 6. Sex 120 148 - 30 - 4066	7. Age (In yrs. la M 2□ F 67		If Under 1 Year Months Days	If Under 24 Hours	Min. May 2, 1	.939 Col	thplace (State or Foreign ountry) nnecticut
	ain with the Maryland 123a or 28a-1 show Usi be rollifiad at	tor	10a. State 10b. County Maryland Baltimore		Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
,	or 28a	Directo	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What C	ountry?
	eain wi	Funeral D	3101 Brandon Hun	t Lane 2. Was Decedent Ever in U.S	S 13 V	210		? (Specify Yes or No-	U.S.A	
36	be lied within 72 hours after death with the Maryland tal Hygiene. Ad other than "natural", or items 23s or 28s-1 show event, the Madical Examinar must be ricitlified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		fYes, specify Cubai	Specify:	? (Specify Yes or No- Puerto Rican, etc.)	Black, Whi	
ည် သ	nature		15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	dent's Usual Occupa kind of work done d DO NOT use retired	ation furing most of	f working	16b. Kind of Business	
Maryland 21215-0036	within iene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		nicial Sup			Computer :	Software
2	be tiled tal Hygir d other event, t	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle, M		
<u> </u>	should be and Mental I s marked o	ဥ	Mariano 19a. Informant's Name/Relationship (Type	Cardillo	10h Mailin	Address /Street a	and Number	Mary or Rural Route Number,	Caruso	Zio Code l
	ss 1 and 2 should b of Health and Ment item 27 is marked r other traumatic e		Barbara Cardillo	Wife				ane Baldwi		1
D .	ges 1 a t of He if Item or oth		20a. Method of Disposition 1 ☐ Burial 2 ★ cremation 3 ☐ R	emoval from State	emetery, cren	sition (Name of natory or other place			20c. Location - City or	
	permit. Pages Department of the important: If ite eny injury or of once.		4 Donation 5 Other (Specify) 21. Signature of Tuneral Service Ligense			Service Co		0-9-2006 Ruck Towsor		Maryland
8 —	Dep imp		Jan Str	gan	10	050 York I	Road	Towson, Ma	ryland 21	204
	Physician /Medical		23a. Part* Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death se tause on each line. HUPER Due to (or as a consequ	TENS		g, such as ca	rdiac or respiratory arre	st,	Approximate Interval Between Onset and Death
60, 2	ate be executed XX bysician and MX the burial-transit and	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
O. Box 68	law requires that the death certificate as been signed by the attending phys 2 shuuld be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ds, P	w requires that been signed b should be deta	ρ	Part II. Other significant conditions con			nderlying cause give	in in Part I.			o the cause of death?
Hecords,	908	Completed	BORDER-CINI	E DIABETE	5 N	ELLITOS	5 /	24a. Was ar autops perform	ad? death?	utopsy findings available complete of
Ita	certificat	BeC	25. Was case referred to medical examiner?					Death Check only one		
Division of Vital	To the Hospital or Attending Physicien: within 24 hours alter death. To the Funeral Director: After this certifics completely filled in by the funeral director. I	၉	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ER/Outpatien 28b. Time of Injury	28c. Injury Work		ng Home 5 Reside		ecity) Work
Divis	after dea after dea Director d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Number or Fi , State)	ural Route Number,
	Nospita 24 hours Punera letely fills	edical C	29a. Certifier 11 Certifying Physical (Check only one) 2 Medical Examination)	inian: To the best of my know er: On the basis of examinati and manner stated.	vladga doath ion and/or inv	somerad at the time vestigation, in my op	€ date and p pinion, death	dana, and due to the ca occurred at the time, da	usa(s) ar dinamer a ite and place, and du	s stated. e to the cause(s)
	To the comp		29b. Signature and title of objection	glen Us		29c. License		5	ed. Date signed (Mon	th, Day, Year)
	15%		30. Name and address of person who do	PIAN M.	D	Print) 16921	Youle	CRD. A	NONKTOI	V MD 2111
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 6 20	32. Registrar's Signat	H A	now				

State of Maryland / Department of Health and Mental Hygien () () 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** October 4, Lee L. Carpenter 2006 4:15 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2 Bonrock Court Towson Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 → M 2 □ F 470-18-0893 March 16,1922 Minnesota Director Usual Residence of Decedent death with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "netural", or Itams 23s or 28s-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Baltimore Towson Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Bonrock Court 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white δ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Engineer Lucent Technologies 12 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any jury or other traumatic event space. 18. Mother's Name (First, Middle, Maiden Sumame) William G. Carpenter Laura Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Baltimore Ave. Suite 100; Towson, MD 21204 Frederick A. Raab attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10/6/06 Towson, MD 21. Signature of Funeral Service Allors 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consi q ince of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 20 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural M 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a (Type, Print) 194 30. Name and address of person while co 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 6 2006

DHMH 17 Rev 1/2001

Registrar

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item# 17, State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death oct. 2, 2006 CALVIN 1:47 A M DOROTHY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARFORD HAVRE DE GRACE HARFORD MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number 6. Sex 08/21/1920 Months Days Hours 1□M 2√F Yrs. MD 213-24-6343 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No HARFORD HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 USA 1500 GLENVILLE ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0,12) College (1-4or 5+) ASSEMBLY WORKER **FACTORY** Pfeifer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) **HENNESEY** HOSPHIOF MARY DANIEL HENRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1500 GLENVILLE ROAD - HAVRE DE GRACE, MD 21078 MARK CALVIN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State BETH TFILOH CEMETERY 10/05/2006 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Feneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease or complications that caused the shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 🗌 Yes 1 Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 Z EN Outpatient 3□ DOA

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

Examiner

Funeral

Director

r then "natural", or itama 23a or 28a-f show the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", eny hijury or other traumatic event, Its Medical Exagnose.

Physician

Maryland 21215-0036

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Certification; To

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25. Was case referred to medical examiner? 1 ☐ Yes 2 🖫 🕹 le 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 SAlatural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a: Certifian Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

(Check only

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Months Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar 31. Date filed (Month, Day, Year) 6 2006

32. Flegistrar's Signature

06-07436 Anthony Davis

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Criticate of Death Registrar Certificate of Death	Reg. No. 20	06 21659
Physician/	1. Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death 2016 hrs
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	15 S. East Avenue Baltimore	,,	N/h
Funeral		24Hrs. 8. Date of Birth (MM/DD/YYYY)	9 Birthplace (State or oreign
Director	220-64-3407 1 M 2 F 4 Z Yrs. Months Days Hours	Min. June 11,1964	Country) NC
any	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location		10d Inside City Limits
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the Maryland a or 28a-f show tified at once.	10e. Street and Number 10f. Zip Code	10g Citizen of What	Country?
tith the Maryland 23a or 28a-f sho notified at once.		4 0	54
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene ris marked other than "natural", or items 23a or 28a-f sho atte event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin 14. Was Decedent of Hispanic Origin 15. Was Decedent of Hispanic Origin 16. Armed Forces? 17. Was Decedent of Hispanic Origin 18. Was Decedent of Hispanic Origin 19. Was Decedent of Hispanic Origin	? (Specify Yes or No- 14. Race - /	American Indian, Black,
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Baltin permit. I Departm. Importa	21. Signature of Funeral Service Licensee	Foreral Senvices	21206
Physician	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car failure. List only one cause on each line.	diac or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease a. Narcotic (heroin) intoxication		Death
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Box 68° e death certificate at the attending ed for use as in the string ed for use as	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		
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10×	O.C.M.E.	October 3, 2	
barg.	30 Name John ss of perso, who completed cause of death (Item 23a)		
4	Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21201	
Stat Registra			

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Month Day October 2, 2006 2324 hrs Medical Examiner BERNARD DAVIS 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital 8 Date of Birth (MM/DD/YYYY 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7 Age (In yrs last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Months Days Hours Min. Director Country) MARYLAND 08/09/1990 218-29-6928 1XXM 2 F 16 Yrs Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 1 X Yes 2 No BALTIMORE MARYLAND N/A notified at once. Director 10f. Zip Code 10g. Citizen of What Country' 10e. Street and Number 21213 U.S.A. 1716 N CASTLE ST. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces? 1 X Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates: 3 Widowed 1 Yes 2 X No specify Specify: BLACK 4 Divorced ই 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ted during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Complet nn of Health and Mental Hygiene it: If item 27 is marked other than " other traumatic event, the Medical 21215-0036 9th grade STUDENT N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MICHELLE FAULKNER ANTHONY JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1716 N. Castle St., Baltimore, Maryland 21213 Michelle Faulkner/Mother Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State ment c tant: or oth BALTIMORE, MARYLAND ARBUTUS 10-10-2005 MEMORIAL PARK Donation 5 Other Specify 22. Name and Address of Facilit 21. Signature of Funeral Service Licensee WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 206 W NORTH AVENUE Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initialed Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Yea Day Month Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ģ 1 Yes 2 V No 3 Probably 4 Unknown نے Completed Records, 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? certificate has performed? ✓ Yes 2 1 🗸 Yes No 25. Was case referred to medical 26.Place of Death (Check only one) **Division of Vital** Be examiner? Hospital: 1 Other 4 DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 Other 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) Oct 2, 2006 After 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending 24 hours after death Certification Subject shot Natural 2116 hrs 1 Yes 2 🗸 No 5 Pending 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) 1700 Block of North Castle Street, Baltimore, M determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. ical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. October 3, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Pamelá E. Southall, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State <u>OCT 0 6 2006</u> Registrar

06-07285 Keith Dawson

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 31658

Reith Dawson		For State	Ji Wai yianu /		ficate of				Reg. N		00 3103		
Physiciar		egistrar . Decedent's Name (First, Middle,Last						L.	ate of Death lonth Da	y Year	3. Time of Death 1650 hrs		
Medical Examin			Matthew]	Dawson		and another of		eptember 2	6, 2006 4c. County of De			
	4	a. Facility Name (if not institution, give Northwest Hospital	street and number)		4	Randalls	, or Location of town	Death		Baltimore C			
Funeral		5. Social Security Number 6. Se	_	(In yrs. last	birthday)	If Under 1	Year If Under	1		IFO	Birthplace (State or preign		
Director	L		M 2 F	29	Yrs.		Jays		2/7/197	76	Country) MD		
ár		Jsual Residence of Decedent 10a. State 10b. County	1	0c. City, To	own or Location	on					10d. Inside City Limits		
ihow a	_ h	Maryland Baltimor	:e	Balt	imore						1 Yes 2 X No		
darylau 28a-f s	Director	10e. Street and Number				10f. Zip Coo			10g.	Citizen of What C	Country?		
th the Maryland 23a or 28a-f show notified at once.	إة	1020 Stormont Cir			12 14/0		1227 f Hispanic Orig	in? / Specifi	/ Ves or No-	USA	merican Indian, Black,		
ath wi	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent B Armed Forces?	No No	If Yo	es, specify Co	uban, Mexican,	Puerto Rica	an, etc.)	White, et	tc.		
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21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	a	Michael Der 19a, Informant's Name/Relationship (7		Dawso		a Address (chele		arie er, City or Town, S	Parks State, Zip Code)		
MD 2 Id 2 shoul Alth and N In 27 is m aumatic	٩	Michael Dennis Da			1020	Storm	ont Cir		Baltimo	ore, MD	21227		
Ce, Realth Health	Ì	20a. Method of Disposition 1 Burial 2 Cremation 3	Pomoval from Sta		ace of Dispos ematory or ot	sition (Name o her place)	of cemetery,	Da	ate 2	20c. Location - Cit	ty or Town, State		
Pages nent of ant: I		4 Donation 5 Other Specify	:	New			emetery				re, Maryland		
Balti bermit. Departu Import njury	21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudo							don Park Funeral Home Baltimore, MD 21229					
Physician	\dashv	23a- Part I. Enter the disease, or com	olications that caused	the death.									
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Kalliner		or condition resulting in death)	Due to (or as a conse	equence of)):								
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause											
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):								
and		d		-									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED	AMENDED							23d. Date of de	eliverv		
876 rtificate ing phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom		2 F	etal death	3 Ectopi	ic pregnanc	у	Month	Day Year		
Box 687 e death certific the attending p ed for use as th	Physician/	1 Yes 2 No 9 Unknow	7n g Unknown	time of dea	ath 5 C	ther (Specify)		-				
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ords, w requir	Completed								24a. Was ar autops perform	у ргі	or to completion of cause of ath?		
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ion tendin leath tor: A	atior	1 Natural 5 Pending 2 Accident Investiga	FOUND: Day, stion Sep 23, 200	6	FOUND: 1300 hrs		1 Yes 2 V	No			Design Number City		
Jivis II or Al after d	Certification:	3 Suicide 6 Could no			ome, farm, str	eet, factory, o	office building, e		or Town, St		r or Rural Route Number, City		
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Birector: A completely filled in by the fil		4 Homicide 29a. Certifier A Continue Physic	ician: To the best of r	ny knowled	ge, death occ	urred at the ti	me, date and p	lace, and di	ue to the cause	e(s) and manner a	as started.		
o the I ithin 24 o the F	Medical	one) 2 Medical Examin	er:On the basis of exa	amination a	nd/or investig	ation, in my o	opinion, death o	occurred at t	he time, date a	and place, and du	e to the cause(s)		
E 18 E 8	Me	29b. Signature and title of certifier	-				License numbe O.C.M.E.	er		29d. Date signed September 2	d (Month, Day, Year)		
		highw,		dogsh /lss	2321		U.U.IVI.∟.			Зорюньы			
4		30. Name and address of person wh Ling Li, MD Assistant	o completed cause of Medical Examine	er 111	Penn Stre	eet, Baltim	ore, MD 21	201					
	tate		2006 32. Régistr	ar's Signati	ure	13456							
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		í	For State Registrar	State	of Maryla	-		nt of Health a te of Death	nd Mei		ene 0 (16	31659
			1. Decedent's Name (First, Middle, La	st)					2.	Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		IRENE GUIO	TT					0	CTOBER	4 2	206	8:45 AM
	Examin		4a. Facility Name (If not institution, giv	e street and nu	mber)			, Town, or Location of	Death		4c. County		
ı			HAMBOR HOSPITA					TIMORE	4115-11				/A
	Funeral		5. Social Security Number 6. S	Sex I□M 252F		. last birthday)	Months Months	Days Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day,		Cour	
	Director		212-46-2592 Usual Residence of Decedent		(33				Feb 28,	1943	Sc	o. Carolina
	and and		10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	10d. Inside City Limits
	Mary	ō	Maryland	N/A				Baltimore					1 🗗 Yes 2 🗆 No
	r 28a	Director	10e. Street and Number				10f. Zi	p Code		10	g. Citizen of V	Vhat Cour	ntry?
	N witt		2828 Carver Road					2122	25			U.S.	A.
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0	or Its		1 Never Married 2 Married	1 Tes	2 N O	i	ii res, spi 1 ⊟ Yes	_	ruello nic	an, etc.)	Specify	k, White,	
21213-0030	ure!',	d by	3 Widowed 4 Divorced	Year or D	ates:			Education appears,			1111		Black
2	72 h	Completed	15. Decedent's En (Specify only highest gra			16a. Dece (Give	dent's Usi kind of w	ial Occupation ork done during most i use retired)	of working	1	6b. Kind of Bu	isiness/In	dustry
V	Parthir	d m	Elementary/Secondary (0-12)	College (1-4or 5+)	iire.		omestic Homen			P	rivate l	Homes
7	illed y Hygie ther t		17. Father's Name (First, Middle, Last,)		<u> </u>				First, Middle, M	laiden Suman	(a)	
and	ntal in do	Be	E- E-W - 14-50	ie Elliott					, , , , , ,		Ross Ellie		
<u> </u>	shoul nd Me mark	6	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	na Addres	s (Street and Number	or Rural R	oute Number.	City or Town,	State, Zic	Code)
Z Z	Trau		Kenneth McDowell So				-	oker T Drive B			-		,
ā,	Hea Hea tam		20a. Method of Disposition		20b.	Place of Dispo	sition (Na	me of	Date	2	Oc. Location -	City or To	own, State
2	ages ent of st: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		State			ery & Mausolet	ım 10	0/10/06	Bro	klyn P	Park, Md.
апшо	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiern 27 le marked other then "nature!", or Iteme 23e or 28e-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		21. Signature of Funeral Service Licer		(1) o			nd Address of Facility					
ă	Depa Depa Impo any is		- JUDENCE 1/2	1/ 101	YOI	M	E	step Brothers I 300 Eutaw Pla	Funeral	Service, F	P. A. 21217		
			23a. Part1. Enter the disease, or com shock, of heart failure. List only	plications that	caused the dea	ath. Do not ent	er the mo	de of dying, such as c	ardiac or re	espiratory arre	st,		Approximate Interval Between
F	Physician		Immediate Cause (Final	_		-ALAI	5.44	DROMÉ					Onset and Death
	/Medical		disease or condition resulting in death)		(or as a conse		7900	DICONIC					
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	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 ☐ Certifying Pt (Check only one) 1 ☐ Certifying Pt 2 ☐ Medical Exar	miner: On the b	asis of examin	nowledge, deatl nation and/or in	occurred vestigation	d at the time, date and n, in my opinion, death	place, and occurred	I due to the ca at the time, da	use(s) and ma te and place,	nner as s and due to	tated. o the cause(s)
	ithin 2 of the simple	Med	29b. Signature and title of certifier	and man	iner stated.		29	c. License number	<u> </u>	29	d. Date signe	(Month	Day, Year)
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	1		30. Name and address of person who	completed carr	Se of death /lea	om 23a) /Tunc		20156			0/4/	OP	
	4							WASTER CT	- A A 1	TIMALE	121	2/22	3-
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			For State Registrar	State of N	Maryland		artment <i>tificate</i>			and M	,	giene Reg. 20.	$\circ \circ \circ$	31660
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	/Medio Examir		4a. Facility Name (If not institution, give	e street and numbe	er)		4b. City, T	Town, or	Location o	of Death			County of Dea	th
*		. ***	6906 Bradford C				Laur		411-4	0411			rince G	
	Funeral Director		5. Social Security Number 6. S 577-42-3780	ex 7.7 □M 2∏F	Age (In yrs. la	ast birthday) Yrs.	If Under 1	Days	If Under a	Min.	8. Date of Bird (Month, Da	y, Year)	C	thplace (State or Foreign ountry)
- 3K	GBC -		Usual Residence of Decedent		77					1	09-24-	1929	Rock	ingham, NC
	ryland how		10a. State 10b. County		10c. City	, Town or Lo	cation			-				10d. Inside City Limits
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	heath ms 23	eral	416 #B Meadows A	Avenue 12. Was Deceder	nt Ever in U.S	5 13 V		2244		nin? /Spe	cify Yes or No		SA 14. Race - Ame	arican Indian
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	and 2 salth a n 27 ls		Denise Williams	/ Daught	er	6906 I	Bradfo	ord (Ct, L	aure	1 MD 20	707		
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Division of	Attendi death. ctor: A y the fu	fical	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of le	njury - At hon	ne, farm, stre			es 2□N		8f. Location (S	treet and	i Number or Ru	ural Route Number.
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	othe cithin 2 of the complet	Medical	one) 29b. Signature and title of certifier	and manner s	stated.			License					signed (Monta	
	F S S		· ondn	Mym	, F	144510	. 1		-	0			-	
0	1		30. Name and address person who d	completed cause of	death (Item 2	23a) (Type, F	Print)			-		0101	per 01	
f)			nd Ro	on 60	96	24 X	J Br	oadi	vay.	Balt	more	plD.	21205
1000	Sta Registr		31. Date filed (Month, Day, Yeal)	32. Filigis	trar's Signatu	B A	aselis			,				
2.30	riegisti	-1	111.1 11 0 2	5 300		- /								

06-07377 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 2006 3166 John Ellis Certificate of Death 1- For State Reg. No Registrar Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 1, 2006 1135 hrs Medical Examiner Ellis John 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 3600 Pulaski Highway If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1965 Months Days Hours Director July 10. Country) MD_ 41 1 X M 218-76-9389 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10b. Count Yes 2 X No 28a-f show Dundalk Maryland Baltimore death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? USA 21222 7717 Meath Road 14. Race - American Indian, Black Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes White Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 4 XDivorced If Yes, Give Year 1 Yes 2 X No specify Specify à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) nt of Health and Mental Hygiene it: If item 27 is marked other than ' other tranmatic event, the Medical Itimore, MD 21215-0036 Logistics Forklift Operator 10 years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian April Dorsey William Henry Ellis 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 19a. Informant's Name/Relationship (Type, Print)

7717 Meath Road,

20b. Place of Disposition (Name of cemetery

Dundalk, MD.

Date

21222

20c. Location - City or Town, State

21222

Day

24b. Were autopsy findings available

death?

✓ Yes

29d. Date signed (Month, Day, Year)

October 2, 2006

prior to completion of cause of

Approximate Interva

Between Onset and

Death

Year

Unknown

No

Physician /Medical Examiner

Examine

Physician/Medical

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Completed

Be

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Certification:

Medical

Homicide

2 🗸

29b. Signature and title of certifie

April Adams

20a. Method of Disposition

and - transit attending physician or use as the burial Division of Vital Records, P.O. Box 68760, nse n signed by the atte page 2 should l this certificate has the Hospital or Attending Physician: After To the Funcral Director:

crematory or other place) October Burial 2 XCremation 3 Removal from State Baltimore City, MD. Bayview Crematory 7,2006 Donation 5 Other Specify Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. Signature of Funeral Service Lag Part I. Enter the disease, or complifortions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Heroin and cocaine intoxication Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): X UNPENDED **AMENDED** item#8,perFH, 23a,27,28a-f,perME,g860, 10/12/06 TT 23d Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 V No 3 Probably 4 24a. Was an autopsy performed? No Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other, Scene 1 V Yes No 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Natural Yes 2 X No Pending Fnd 10/1/2006 Fnd 11:00 am unk 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc Location (Street and Number or Rural Route Number, City or Town, State) 3600 Pulaski Hwy. Town, State) 3 3 6 X Could not be Suicide Baltimore,

Mother

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Tasha Greenberg MD. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2005 Registra

determined

(Specify)

and manner stated

MAG

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

found in hotel room

State of Maryland / Department of Health and Mental Hygiens 31662 For State Registra 1-Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death october **Physician** Ferrare Clementina 835 AM 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Good Samaritan Novsing Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 88 217-05-8165 Yrs Director 5,2006 Oct. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1XX es 2 No Maryland N/ABaltimore City Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 238 21239 6115 D The Alameda United States death ' Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ۵ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physical Education Teacher Baltimore City Schools 12 4 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental F 27 is marked of traumatic ever Joseph Ferrare Mary Kufel 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Itam 27 i Mrs. Anita L. Sipes (Great Niech) 3309 Hiss Avenue, Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If Its any Injury or ot once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel Oct. 6,2006 Forest Hill, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral&Cremation Ctr. P.A.
2325 York Road, Timonium, Maryland 21093 21. Signature of Funeral Service Licensee, 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Staphylo coccal bacteremia **Physician** dai /Medical Due to (er as a consequence of): Examiner obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical ijβ attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ne cologic 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has certificate 2 Z No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Soursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Aftert Certification: Natural 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 3 🖺 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check one) 29b. Sign ture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46504 Good Samanitan Hospital Baltimore 21239 30. Name and address of per ho completed cause of death (Item 23a) (Type, Print) Friedley MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar 6

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Year 6:40a M **Physician** Oct.5 2006 Lawrence R. Franczkowski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months Days Hours Min. | Jan 1944 | Machinal And Machinal 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1∰M 2□F 215-40-4182 62 Yrs. Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "neturel", or iteme 23a or 28a-f ehow the Medical Expolper roust be notified at Baltimore Essex MD 1 Yes 2 No **Funeral Director** 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 21221 815 Glass Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? YE Yes 2 No Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor MTA permit. Pages 1 and 2 should be filed v Depertment of Health and Mental Hygies Important: if Item 27 is marked other th eny injury or other treumatic event, that page. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Tillie Gajdzicka Adam Franczkowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lorraine Franczkowski 815 Glass Avenue Baltimore MD 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XOSurial 2 ☐ Cremation 3 ☐ Removal from State 10/9/06 Baltimore MD Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signa ure of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listionly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ymphom 4 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner physician and is the burial-transit The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Dav 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Lenal cancer 1 ☐ Yes 2 ☐ No 3 1 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t autopsy performed? 1 ☐ Yes 1 Yes 2 No 2 20 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٢ 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending efter death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours e • Funeral I 29a. Certifier TEXENTITY Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCTUBER 5 2006 D58303 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barruse 40 21204 After Charles up 6601 N. Charles St 31. Date filed (Month, Day, Year) OCT 0 5 2006 2. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure	e All Copies Are Legible.	
State of Maryland / Department of Health an Certificate of Death	nd Mental Hygiene 006	31664
rnn Fulton	2. Date of Death Month Day Year October 4. 2006	3. Time of Death 11:00 PM M

Phy /M Exa

1 - For State Registrer

Fund

Direc permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 2715 marked of other than "natural", or items 23a or 28a-f show any injury or other than the Marical Eye when the mortilised as any injury or other traumatic event the Marical Eye when the mortilised as

Baltimore, Maryland 21215-0036

Physic /Medi Exami

To the Purpspital or "standing Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Purpspital purpspit of the properties that been signed by the attending physician and commodivate strings in the strangled properties of description and 2 should be described for use as the burisht reast.

Division of Vital Records, P.O. Box 68760,

an	1. Decedent's Nam Melodye									Month Octobe	Day	, 2006		ime of Death :00 PM M
al er	4a. Facility Name (f not institution,	give street and numi			4b. City,	, Town, or	r Location	of Death	00000		County of Deat	h	
CI	Gilchris	t Cente	er for Hos	pice C	are			Towsc	n		Ba	ltimore	8	
	5. Social Security N 217-70-0		6. Sex 7	. Age (In yrs. 50	. last birthda Yrs.	y) If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Da 09/16	" "1"956	9. Birt	hplace (S untry)	State or Foreign
	Usual Residence o			100 C	ity, Town or	Langtina							10d Inc	side City Limits
ō	10a. State	10b. County Balti	more		rkton	Location								JYes 2√€ No
eci	10e. Street and Nu	L				10f. Zir	p Code				10a. Citiz	zen of What Co	ountry?	
2 2	1611 Mt.		Road				120				USA			
/ Funeral Director	11. Marital Status	_	12. Was Deced Armed Force ed 1 Yes 2	es? ⊇⊠No	J.S. 13	3. Was Dece If Yes, spe	cify Cuba	ispanic Ori an, Mexical Specify:	n, Puerto	ecify Yes or No Rican, etc.)		4. Race - Ame Black, White	e, etc.	ian,
o D	3 XWidowed		Year or Dat	es:	1 10 5							Specify: Whi		
Completed			t grade completed)		(Git	edent's Usu ve kind of wo . DO NOT u	ork done	during mos	it of worki	ng		nd of Business/ cation		ersity
5	Elementary/Seco	ondary (0-12)	College (1-4	4or 5+) 4	Stuc			-/			Leve	el		
- o ae C	17. Father's Name William				•					(First, Middle ne Saund		Sumame)		
-	19a. Informant's N Deborah					-				al Route Numb	-	Town, State, 2 21120	Zip Code))
			3 □Removal from Specify)	tate	Place of Dis cemetery, co nesape	ematory or	other plac	1		oct 7 2006		cation - City or		
	21. Signature of Fe	uneral Service L	Licensee R. H.	Malu	113					l Alter Orive I		es nore, Ma	ryla	nd
	23a. Part1. Enter	he disease, or	complications that car	used the dea	th. Do not e	enter the mo	de of dyin	g, such as	cardiac c	or respiratory a	ırrest,			oximate val Between
	Immediate Cause	(Final	only one cause on ea	CO W	044	100	en	10	ul.	0.00	41.		0000	t and Death
	disease or condition resulting in death)		a Due to (o	ras a Ase	quence of):	0	0	1/	Com	1	1	l, diseasi		1
	0			PO	BU	re	Cre	UTE	Tel	91-14	+ Kb6	diseas	e	mari
Examiner	Sequentially list co	nditions, nmediate	b. Due to (o	r as a conse	quence of):									
	cause. Enter Under Cause (Disease or that initiated event	S	С.											
	resulting in death)	Last	Due to (o	ras a conse	quence of):									
S			d											
clan/medical	IF FEMALE:		00. 1/ 0.											
2	23b. Was deceder in the past 12			th 2 Fet	al death	B □Ectopic p		,			2	3d. Date of dei Month	livery Day	Year
rnysic	1 ☐ Yes 2 9 ☐ Unknowr	₽ No	4∐Pregna 9□Unknov	nt at time of o	death 5	5 ☐ Other (s	pecify)						,	
			ns contributing to dea	ath but not re	sulting in the	underlying	cause aiv	en in Part I	i.	23e. Did	tobacco u	se contribute to	the cau	se of death?
ב ב					g	,	y.*				Yes 2			4 Unknow
3000										24a. Was		,	itansy fin	dinos availabl
										auto	psy ormed?	death?	_	idings available on of cause of
)	25. Was case refe	read to madical						00.51	- / D 1	1 Yes	2□No	1 ☐ Yes	2 1 N	10
	examiner?		Hospital:	patient 2	☐ ER/Outpat	ient 3□ D	OA Oth	05		n <i>(Check only</i> me 5 ☐ Res		Other (Spe	cife) /	tripic
	27. Manner of Dea		28a. Date of (Month		28b. Time	of	28c. Injur	y at		28d. Describe			city) V	10.0
STEP STORY	1-☑Natural 2 ☐ Accident	5 Pending investig		, Day Year)	Injury	M	Wor	k? Yes 2.⊡	No					
	3 Suicide	6 ☐ Could r	not be 28e. Place of	of Injury - At h	nome, farm,	street, factor	ry, office					Number or Ru	ural Rout	e Number,
	4 Homicide		buildin	g, etc. (Speci	ity)					City or 10	wn, State)			
ופחוניםו כ	29a. Certifier (Check only one)	1 Certifyin 2 Medical I	g Physicien: To the t Exeminer: On the bas and manne	sis of examin	owledge, de ation and/or	ath occurred investigation	d at the tir n, in my o	ne, date ar pinion, dea	nd place, ath occurr	and due to the	cause(s) date and	and manner as place, and due	s stated.	ause(s)
E	29b. Signature and	title of certifier	1					e number				e signed (Mont		
	> M	And	2000	ly,	mo	2	2	520	5		Oct	obero	5,	2006
	30. Name and add	ress of person	who completed cause	of death (Ite	m 23a) (Typ	e, Print)					- 7	d Zi		
	W.	A. R.	lay GA	inc	6701	N-	Cha	les.	St. 1	Salto	-m	1 51	200	•
e	31. Date filed (Mo	nth, Day, Year)	200C 32 Re	gistrar's Sign	ature	A		-						
r		ICT 0 6	2006	gora s	O. All	mente								

Registrar

			For State Registrar	State of M	aryland		artment tificate					Reg. No.		316	65
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Michael A.		Sr.						2. Date of D Month OCt.		2006 ear	3. Time o	P M
-	Examin		4a. Facility Name (If not institution, give s 503 Hillside R				4b. City, T Es	own, or L	ocation of	Death			County of Dea Baltim		
4	Funeral Director		5. Social Security Number 453-72-8941 6. Sex	7. Ag	ge (In yrs. las 59	t birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of B (Month, L July	Day, Year)	9. Bir	thplace (State ountry) EXAS	or Foreign
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1									10d. Inside C	City Limits
	the Mar 28a-1 et	Director	FL Volusia		De	lton	10f. Zip	Cada				10a Cit	izen of What C		2 X No
	23a or	ai Dir	608 Eldron Ave					2738	3			US		ounity?	
036	urs after dea ai', or itema	by Funerai	11. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 If If Yes, Give Year or Dates:	,		Was Decede f Yes, spect 1 ☐ Yes 2			jin? (Spec Puerto F	cify Yes or N Rican, etc.)	10-	14. Race - Am Black, Whi Specify: W	te, etc.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene. Important: if Item 27 is marked other than "natural, or itema 23a or 28a-1 show any injury or other traumatic event, the Medical Event as must be invitted at another.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation of completed) College (1-4or) 4 VYS		(Give	lent's Usual kind of work DO NOT use ter	done du		of workin	ng		ind of Business ne Imp	•	ent
yland 2	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Robert Garber					1			(First, Middle Dobb		Sumame)		
Mar	nd 2 sho alth and 27 is mu ir traumu		19a. Informant's Name/Relationship (Ty, Cathy Garber	pe, Print) / wife			_						32738	Zip Code)	
Baltimore, Maryland	Pages 1 and neut of Healint: if item		20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place Certification Bay	ce of Disponetery, crem VV1eW	sition (Nam natory or oth Cre	e of her place) matc	ory	1	ate 1/00		cation - City or Ltimor		
Balt	permit. Departr importa any inje		21. Signature of Funeral Service License	90	11	1 22	. Name and	Address ≥11y	of Facility Fun	30 era	0 Mac 1 Hom	e Av	ye. Ba E Esse	lto. M x 2122	ID 21
*			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ne cause on each li	ine.	1.							20.	Approxima Interval Be Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as	oscle/ a consequer		car	dic	va	SCV	ilan	11126	ase		
6	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	nce of):									
o,	tate be executed the site of the purial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):									
68760,	ficate be physicials to the bu	edicai		J											
O. Box 6	that the death certificate be executed the by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 🗌 Fetal de	eath 3□]Ectopic pre] Other (spe						23d. Date of de Month		Year
ds, P.O	9 5 9 9	by	Part II. Other significant conditions cor	ntributing to death b	out not resulti	ng in the ur	nderlying ca	use given	in Part I.			tobacco u	use contribute t		death? Unknown
Recor	The law requir ate has been si page 2 should	Completed										is an opsy formed?	24b. Were a prior to death?	utopsy findings completion of	available cause of
ital		Be Co	25. Was case referred to medical examiner?					:	26. Place	of Death	1 ☐ Yes (Check only		1 🗆 Ye:	s 2 No	-\ - \ -\ -\ -\ -\ -\ -\ -\ -\ -\ -\ -\ -\ -\
Division of Vital Records,	Phys this aldi	၉	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 lnpati 28a. Date of Inju (Month, Da	ury 2	NOutpatien 8b. Time of Injury		Bc. Injury a Work?	4 1101	2	ne 5 ☐ Re 8d. Describe		6 Other (Sperry occurred	ecify) Hov	M €
Divis	after des after des Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At homitc. (Specify)	e, farm, str	eet, factory,	office		2	8f. Location City or T	(Street an own, State	nd Number or R	lural Route Nur	nber,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination		of examination										s)
	To the Vithin To the compl	Me	29b. Sign thre and the of certifier	w 1 -	1.		525	License		9			te signed (Mon		
,	10		30. Name and address of person who co	1111	eath (Itom 2	За) (Туре,	Print)	11 ~	ا ما <i>ه</i> المريا	lan a	11-	MA	2109 2109	2000	•
	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signatur	Louis	e Hi	···CL	. <u>- u 1</u>	ישאנ	יוויל	710	210	13	1
	Registi	ar	OCT 0 5 2006	September 1	13. P										

DHMH 17 Rev 1/2001

				aryland / Dep <i>Ce</i>		ealth and M	lental Hy	•		31666
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Delia V. Garcia				2. Date of Dea Month 09		2006	3. Time of Death 3:30p M
	Examir		4a. Facility Name (If not institution, give street and number) 649 Cedar Spring St.		Gaither			Mont	nty of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2√ F 7. Ag Usual Residence of Decedent	e (In yrs. last birthday, 85 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) 5-30-1	h y, Year) 921	9. Birthp Coun Cuba	lace (State or Foreign try)
	Maryland	tor	10a. State 10b. County MD Montgomery	10c. City, Town or L Gaithers					1	0d. Inside City Limits 1 ☐ Yes 2☐No
	th with the 23a or 28e	ai Direc	10e. Street and Number 649 Cedar Spring St.		10f. Zip Code 20877			10g. Citizen o	f What Coun	try?
980	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "naturel", or items 23e or 28e-f ehow imatic event, it a Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☑ Yes 2 ☐ No				ace - Americ lack, White, cify: Whit	etc.
1215-0	within 72 ho ene. then "natur he Medical	mpieted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4ors	(Give	edent's Usual Occupa e kind of work done o DO NOT use retired tronic Te	luring most of worki)	ng	16b. Kind of		of Defense
Maryland 21215-0036	id be filed v fental Hygie rked other i ilc event, it	To Be Co	17. Father's Name (First, Middle, Last) Antonio Vila	2200	rionic le	18. Mother's Name Flora R		-		or bereits
, Mary	and 2 ealth at n 27 le		19a. Informant's Name/Relationship (Type, Print) Edward Garcia/son	649	ing Address (Street a	ing St. G	aithers	burg,	MD 208	377
Baltimore,	permit. Pages 1 Department of H Important: If Iter any injury or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Chesapea	osition (Name of matory or other place). ke Cremators. 2. Name and Address	ory 9-25			ille,	MD
Ba	Derm Depa Impo		23a. Part1. Enter the disease, or complications that caused	135 8 R	app Funer	al & Crem			ing, A	Move. 20910 Approximate Interval Between
68760,	ficate be executed Examiner by physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of): a consequence of):						
P.O. Box	at the death certificat by the attending phy tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2X No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				Pate of delive Month	ry Day Year
	requires the been signed should be de	ρ	Part II. Other significant conditions contributing to death b	ut not resulting in the u	underlying cause give	on in Part I.	1 🗆 Y	es 2□No	3 Prob	
Vital Records,		Be Completed	25. Was case referred to medical examiner?			26. Place of Death		med? MIXNo	prior to cor death? 1 \(\sum \text{Yes}\)	osy findings available inpletion of cause of
Division of V	ding Phys I. After this funeral di	Certification: To	27. Manner of Death 1\(\sum_{Manner} \) S Death 1\(\sum_{Manner} \) S Death 28a. Date of Inju (Month, Da) 29a. Codent 1\(\sum_{Manner} \) Accident 29a. Date of Inju (Month, Da)	y Year) 28b. Time o	of 28c Injury Work M 1 \(\sigma\)	at ? /es 2 No	28d. Describe h	ow injury occi	urred	,
Divi	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the		4 Homicide determined 298. Pace of in building, et	ury - At home, farm, st c. (Specify) of my knowledge, deat	th occurred at the tim	e, date and place, a	City or Tow	m, State) cause(s) and r	manner as st	I Route Number,
)	To the Howithin 24 To the Force completel	Medical	29b. Signature and title of certifier Medical Examiner. On the basis of and manner st. 29b. Signature and title of certifier Moul An	ated.	200 Lionaca	number		29d. Date sign	ned (Month, I	``
	0		30. Name and address of person who completed cause of c James Anchors M.D. 16220 Ft	rederick Ro	l. Ste.210	Gaithers	sburg, N	① 2087	7	
DH	Sta Registi MH 17 Rev 1/2	ar	31. Date filed (Month, Day, Year) 32. Registr	ars Signature						
				ORTG	INAL					

				For State Registrar	State of Ma	-	partment of ertificate of	Health and N Death		iene 2006	31667
4	1	ysiciai Medica amine	1	Decedent's Name (First, Middle, Last) Erna C. Grebe 4a. Facility Name (If not institution, give si	reet and number)		4b. City, Town,	or Location of Death	2. Date of Death Month	Day Year 04 2006 4c. County of Death	3. Time of Death 9:50 AM M
	Fur	eral ector		214-01-1008	7. Age	(In yrs. last birthda 90 Yrs.			and 8. Date of Birth (Month, Day, 05/16/19		nplace (State or Foreign untry) "Yland
. 1	death with the Maryland	fiedat	tor	Usual Residence of Decedent		10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
20 可	h with the	at be not	al Director	10e. Street and Number 1104 Mill Creek Ro	oad		10f. Zip Code 21047	7	10	Og. Citizen of What Co	untry?
KFR	Fre, Maryland 21215-0036 Is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.	Examiner mu	a by Funeral		2. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ver in U.S.		Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- Prican, etc.)	14. Race - Amer Black, White	
0	21215-C ad within 72 h giene.	the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(Gi life	cedent's Usual Occi ye kind of work don DO NOT use retir	e during most of work	sing	Trucking	-
RNA	Maryland 2121 nd 2 should be filed within Ith and Mental Hygiene.	umatic avant	lo Be	 17. Father's Name (First, Middle, Last) Frederick Hinz 19a. Informant's Name/Relationship (Typ 	e, Print)	19b. Ma	iling Address (Stree	Anna F		laiden Sumame) City or Town, State, Z	ip Code)
上窓日	Saltimore, Mc	ry or other trac		Walter F. Grebe, 20a. Method of Disposition 1 D Surial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		20b. Place of Dis cemetery, c	3 Hillcro position (Name of rematory or other pl d Cemeter	ace)	Date 2	Hill, Mar 20c. Location - City or Baltimore	
	Baltimol	any inju		21. Signature of Funeral Service License	sachn		22. Name and Add	ress of Facility E.	F. Lass		l Home, P.A.
	S8760, Loate be executed Exam.	ine purial-transit	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a).	0	ring, such as cardiac			Approximate Interval Between Onset and Death
	of Vital Records, P.O. Box 687. Physician: The law requires that the death certificate his certificate has been stoned by the attending physics.	detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death	□Ectopic pregnan	су	75	23d. Date of deli Month	very Day Year
	ords, Popular of the provided to	2 3	<u>~</u>	Part II. Other significant conditions cont	nbuting to death but	not resulting in the	underlying cause g	iven in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to	
	al Recon: The law reconcide has be	CA 1	Completed						24a. Was an autopsy perform 1 Yes 2	v prior to c	opsy findings available ompletion of cause of
	Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death. To the Funeral Director. After this certificate has been stoned by the	by the funeral directo	Certification: 10 be	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	of 28c. Injury	ther: 4 Nursing Houry at ork? Yes 2 No	28d. Describe ho	nce 6 Other (Spec w injury occurred	
	Hospital o	etely filled in	Medical Cer	29a. Certifier 1 1 Certifying Physi (Check out) 2 Medical Examin	cian: To the best of er: On the basis of e and manner state	examination and/or	ath occurred at the investigation, in my	time, date and place, opinion, death occur	and due to the ca	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the within	compl		29b. Signature and title of certifier 30. Name and address of person who cor MYO NIN (h. D.)	1 ^			1se number 45390	299	od. Date signed (Month	Day, Year) 2006
		State	е	30. Name and address of person who cor MYO MIN (h. 0.) 31. Date filed (Month, Day, Year)	32. Registrar	ath (Item 23a) (Typ) (Item 23a) (Typ) (Item 23a) (Typ) (Item 23a)	phia Ac	oad #2	08,80	altimore,	MD21236

State of Maryland / Department of Health and Mental Hygiene 2006 31668 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2006 October 0 Derrick Elmer Garner 8:20 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery 7. Age (In yrs. last birthday)
Yrs.

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Jan. 28) 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** 1 AM 2 ☐ F Michigan Jan. Director 371-56-1557 Ĩ950 Usual Residence of Decedent the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show rither must be notified at 1X Yes 2 No Montgomery Directo Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 15100 Donna Drive 20905 USA Pages 1 end 2 should be filed within 72 hours after death ment of Heelth and Mental Hyglene.
ant: if team 27 is marked other than "natural", or Itema 23 ury or other treumatic event, the Medical Experimental ury or other treumatic event, the Medical Experimental by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☒ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widgwed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Substation Tech Pepco Holding Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Elmer Garner Myrtle Marie Howard 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $15\,100$ Donna Drive LaShawn F. Garner/Wife Silver Spring, Md. 20905 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State rtment of h cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 10-5-2006 Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Marshall's Funeral Home, Inc. Dep 4217 9th St. N.W. Washington, D.C. 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY **Physician** FAILURE DAY /Medical Due to (or as a consequence of): Examiner -UNG CARCINOMA METASTATIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physicien and s the burial-transit or Attending Physician: The law requires thet the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical anding pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery atter for u 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) ned by the a deteched f 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. s been signer Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s 2 No 1 🗆 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. neral Director: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Directompletely filled in by 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) + OCTOBER 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AYOS 18101 Prince Philip Dr. Olney, MD 20832 URTIS W. 32. egistrar's Signature 31. Date filed (Month, Day, Year) State 05 OCT 2006 Registrar

			For Stete Registrer	State of Ma	aryland	d / Depa <i>Cer</i>	irtment of h tificate of	Health and <i>Death</i>	Mental Hygie	2008	31669
	Physici /Medic		1. Decedent's Name (First, Middle, Las Nicholas	Charles	Guer	ieri			2. Date of Death Oct. 3,	2006 Year	3. Time of Death 5:20 P M
	Examin		4a. Facility Name (If not institution, give					or Location of Dea	th	4c. County of D	eath
			9440 Seven Courts 5. Social Security Number 6. Se		(In vrs. la	ast birthday)	Not If Under 1 Year	tingham	s. 8. Date of Birth		timore Birthplace (State or Foreign
ı	Funeral Director			CXM 2□F	87	Yrs.	Months Days	Hours Min	(Month Day Y	1919 N	lary land
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	eth with the Marylar 23e or 28e-f ehow	ţō	Md. Balti	more			Nottin	ιαham			1 ☐ Yes 2 🖾 No
	or 28s	Director	10e. Street and Number	mor c			10f. Zip Code	igitalli	10g	. Citizen of What	Country?
	s 23a	ral	9440 Seven Courts					21236		USA	
_	tiled within 72 hours atter deeth with the Maryland Hygiene. tther than "natural", or items 23s or 28s-f ehow int, the Macilcal Examinat must be notified at	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 XYes 2 N		5. 13. V	Vas Decedent of F Yes, specify Cub	dispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
21215-0036	ours a	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWI	I 1	☐ Yes 2💢 No	Specify:		Specify:	White
ק	be filed within 72 ho ital Hygiene. id other than "natur event, Ira Modical	Completed	15. Decedent's Ed (Specify only highest grad			(Give	ent's Usual Occup kind of work done OO NOT use retire	during most of we	orking 16	b. Kind of Busine	ss/Industry
7.	iene.	omo	Elementary/Secondary (0-12)	College (1-4or 5	+)	me. L	Electri	•		Indi	ıstrial
	0 2 2 5	BeC	17. Father's Name (First, Middle, Last)						me (First, Middle, Ma		
<u>Z</u>	should be nd Mental i marked c	인	Peter Nazzere		^i		_		Taide B		
Maryland	2 2 2 2 2		19a. Informant's Name/Relationship (7) Mrs. Patricia Guer	-					lural Route Number, C Nottingham		
ē,	s t and f Health item 27 other te		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name of patony or other place			c. Location - City	
Ē	Pages ment of it ant: if its arry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🔀 Other (Specify		1				0/7/06 Ti	monium,	Maryland
Baitimore,	permit. Page Deportment Important: if any injury or once.		21. Signature of Funeral pervice Licent	P°/1 0	1		Name and Addre				Home, Inc.
	40244	8 9	23a. Part1. Enter the disease, or comp	lications that caused	the death.		50 York		wson, Mary		04 Approximate
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on each lin	е.		,			1	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a	conseque		Leural	EFFL	ISUM_		
	Examiner	-	Sequentially list conditions,	b. Charles for an	ar the second	and the same of th					1 ac
	nsit	mlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	t conseque	ence otj.					
o	execuen and rial-tra	Examin	resulting in death) Last	Due to (or as a	conseque	ence of):					
2/60	cate be executed physicien and the burial-transit	dlcal		d							
× S	certific ding p	0	IF FEMALE:	23c. If yes, outcome of	of pregnan	icy				23d. Date of	tolinon.
ž Ros	uires that the death certifi signed by the attending d be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth :			Ectopic pregnancy Other <i>(specify)</i> _	<i>f</i>		Month	Day Year
л Э	at the	Phys	9 Unknown	9□ Unknown							
g,	requires that een signed b hould be deta	þ	Part II. Other significant conditions co				derlying cause giv				to the cause of death? Probably 4 Unknown
Hecords,	been shoul	lete	FORMER SME ASCVD,	CHE					24a. Was an		autopsy lindings available
E E	0 5 0	Completed	713CV 23 , 1						autopsy performed	d? prior i	o completion of cause of
Vital		BeC	25. Was case referred to medical examiner?						ath Check only one	INO ILI	es 45140
5	Physician: this certific ral director.	5	1 ☐ Yes 2 No 27. Manner ol Death	Hospital: 1 ☐ Inpatier		R/Outpatient		4 🗆 Nul Silly I	Home 35 Residence		pecify)
	Attending or death.	tlon	Natural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day	Year) "	28b. Time of Injury	28c. Injur Wor M 1 🗆	yat k? Yes 2∐No	28d. Describe how	injury occurred	
UNISION	l or Attendi efter death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ry - At hom	ne, farm, stre	et, lactory, office		281. Location (Stree City or Town, S	et and Number or	Rural Route Number,
5	urs eft orai Di										
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying Phy Certifying P	sician: To the best of ner: On the basis of and manner star	examınatıd	dedge, death on and/or inv	occurred at the tire estigation, in my o	ne, date and place pinion, death occi	e, and due to the caus urred at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	To th within To th comp	Me	29b. Signature and title of cartifier		$\overline{}$		29c. Licens	e number	29d.	Date signed (Mo	nth, Day, Year)
	- 1						1000	477.	02 (OCT. 5	2006
1	$Y_{X,i}$		30. Name and address of person who co	ompleted cause of de	ath (Item 2	23a) (Type, F	rint)	Nic	K Mel	isarat	1002
, ,	Sta	te	31. Date filed (Month, Day, Year)	32. Riegistra	r's Signatu	ire		1 . 6 . 1	OHOM, I	IN X	10-15
Ť.	Registr		OCT 0 6 20	06	and the	Y.	all)				
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ORIGINAL

			1 - State Amend #12	State of M Per FH G86	laryland 60 10 /	d / Depa /16/<u>%</u>	artment of F	lealth <i>Death</i>	and Mental H	ygier Reg. 1	2006	5 3	11670
¥ -	Physici	÷	1. Decedent's Name (First, Middle, La	st)					2. Date of I		Day Y	ear	3. Time of Death
	Physici /Medi		Steven	P.				ein	eroctob	ER.	2 Z	006	3:55 AM
	Examir	ner	4a. Facility Name (If not institution, given The Control of the Co		* 1		4b. City, Town, o Baltin			4	4c. County of	Death	
	Funeral				ge (In yrs. I	ast birthday)	If Under 1 Year	If Under	24 Hrs. 8. Date of I	3irth	. 9	. Birthplac	ce (State or Foreign
100	Director		199-34-9415	M 2□ F	63	Yrs.	Months Days	Hours	Min. 0ct 1	1°	43 F	COUNTRY	ylvania
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d	. Inside City Limits
	72 hours after death with the Maryland natural', or Items 23s or 28s-1 ehow disal Examinativity be putilled at	ō	DC			ningto							1 No Yes 2 No
	r 28a-	rect	10e. Street and Number		nasi	rring co	10f. Zip Code			10g. (Citizen of Wh	at Country	?
	th with	a D	5324 41st Street				20015			US	A		
	r dea	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S	S. 13.	Was Decedent of H	lispanic Or an, Mexica	rigin? (Specify Yes or In, Puerto Rican, etc.)	No-	14. Race - Black,	American White, etc	
36	s afte	by Ft	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			1 ☐ Yes 2 ☐ No	Specify.	:		Specify:	whit	
21215-0036	2 hours		15. Decedent's E			16a. Dece	dent's Usual Occup	ation		16b.	Kind of Busir		
212	Br. "n Medi	Completed	(Specify only highest grant [9] Elementary/Secondary (0-12)	ade completed) College (1-4or	5+)	life.	kind of work done of DO NOT use retired	d)	st of working				
2	ed wil	Con	12	5		Syste	ns Engine				nsulta	nt	
nd	be fill d off	Be	17. Father's Name (First, Middle, Last						er's Name (First, Midd Lavon Care		en Sumame)		
Maryland	hould d Mer mark matic	2	William Edward Gr			19h Mailir	a Address (Street		er or Rural Route Nun		v or Town St	ate Zio Co	ndel .
Z	th an		Margaret Kreitzer						Washington			116, Zip O	Jue)
ē,	f Hea item		20a. Method of Disposition		20b. PI	Access to the second se	sition (Name of natory or other place		Date	-	Location - Ci	ty or Town	n, State
Ë	Page nent o int: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		9		Crematory	1	10/5/06	Sc	haeffe	rstow	vn, PA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23s or 28s-f show any injury or other traumatic event, the Medical Examples Industrial Property 2016.	/	21. Signature of Funeral Service Light	see /		22	. Name and Addre	ss of Facili	ity Ruck Tow				
Ш	205 29		frefer by	ne Va					Towson, MD		204		
60			231. Part1. Enter the disease, or och shock, or hear failure. List only	one cause on each	ine.	Do not ent	er the mode of dyin	ng, such as	cardiac or respiratory	arrest,		ln O	pproximate iterval Between inset and Death
	Physician /Medical	4	Immediate Cause (Final disease or condition resulting in death)		igal	Pine	umonic	2				/	16 Days
200	Examiner		1	Due to (or as		reloid	1 enhem	11.6				2	16 Days
C 1		Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	s a consequ	ence of):	Certain						years
C.	cuted nd ransit	Examin	that initiated events	С									
ŏ,	e exe zian al urial-l	EX	resulting in death) Last	Due to (or as	s a consequ	ence of):							
8760,	icate be executed physician and s the burial-transit	dica	•	d									
9 X	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnar	ncy					23d. Date of	of delivery	
Box	death s atter d for u	iciar	in the past 12 months?	1□Live birth 4□Pregnant a			Ectopic pregnancy Other (specify)	/			Month		ay Year
P.O.	that the de ned by the a detached f	hys	9 Unknown	9□ Unknown									
	The law requires that the ste has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions	contributing to death	but not resu	Ilting in the u	nderlying cause giv	en in Part I			-	ute to the o	cause of death?
ord	sen si	ted							1[] Yes	2 No 3	Probab	ly 4 □Unknown
Sec	has by	Completed					<u>-</u>		24a. Wi	topsy	prio	or to comp	findings available letion of cause of
a F	ician: Th certificate rector, pag								1 □ Yes	formed?			□ No
Division of Vital Records,	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ② No	Hospital:	inat 0.01	- D/O +- +	• all poal Oth	ar.	e of Death (Check only		a [[] 0.1	(0 ()	
ō	Phys ar this aral di	n: To	27. Manner of Death	28a. Date of Inj	ury	ER/Outpatien 28b. Time of	1 3LI DOA	4 🗆 141	ursing Home 5 Re 28d. Describ		6 Uther		
io	Attending in death.	atio	1ÆNatural 5 ☐ Pending 2 ☐ Accident investigatio	(<i>Month, Da</i> n	ay Year)	Injury		k? Yes 2.⊟	No				
i∑i	I or Attendated after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	njury - At hor		eet, factory, office			(Street	and Number	or Rural R	oute Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page												
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier (Check only one) Certifying Pl 2 Medical Example (Check only one)	niner: On the basis	of examinat	vledge, death ion and/or in	occurred at the tin restigation, in my o	me, date ar pinion, dea	nd place, and due to thath occurred at the tim	e cause e, date a	(s) and mann and place, and	er as state d due to th	ed. e cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	and manner s			29c. Licens	e number		29d. [Date signed (/	Month, Da	y, Year)
)	F \$ F 0		Manning /X	alles, N	Tedical	Docto	- Be	5-00	0	17	5/3/06		
	. 1.		30. Name and address of person who	completed cause of	death (Item	23а) (Туре,	Print)	` .	1.6	, -	1-6-6		21287
	12		Channing Paller, The	Johns Hop	Kins He	spital	, 600 No	-th u	oo Volfe Stree	t, 13	altiner	re Mi	artyland
	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signat	ura							V
Dur	Registi	4	OGT 0 6 2	2006	all and the	de de	2346						
שט	MH 17 Rev 1/2	JUI				ORIGIN	JAL						
							-						

06-07397 **UNK UNK**

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		Registrar	icate of Death	Reg No. 200	6 3 1 6 7
Physici: Medical Exami		1. Decedent's Name (First, Middle,Last) STUART E.	GRIFFITH	2. Date of Death Month Day Year October 2, 2006	3. Time of Death 0114 hrs
		Facility Name (if not institution, give street and number) South Calvert Street	4b. City, Town, or Location of D Baltimore	eath 4c. County of Dea	n/A
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last t		· .	rthplace (State or
Director		220-21-2163 1X M 2 F 35 Usual Residence of Decedent	Yrs. Months Days Hours		ountry) NY
v any	1	10a. State 10b. County 10c. City, Tov	wn or Location		10d. Inside City Limits
faryland 28a-f show any 1 at once.	į	MD BALTIMORE OWI	NGS MILLS 10f. Zip Code	10g. Citizen of What Co	1 Yes 2 X No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	4 QUERN COURT	2111		USA
ath with items 2:	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.) 14. Race - Ame White, etc.	rican Indian, 8lack,
after de	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify	Specify Bla	ck WHITE
2 hours "natur		15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	 Decedent's Usual Occupation (Give kind during most of working life. DO NOT use 		/Industry
0036 within 72 gene. ner than "	Completed	12	MUSICIAN	MUSIC	
21215-00% and be filed within Mental Hygiene marked other to event, the Med	Be C	17. Father's Name (First, Middle, Last) RONALD GRI	FFITH PAME	ame (First, Middle, Maiden Surname)	CHASE
Baltimore, MD 21215-0036 oemit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than nijury or other traumatic event, the Medica	٩	19a. Informant's Name/Relationship (Type, Print) PAMELA CHASE GRIFFITH / MOTHER		or Rural Route Number, City or Town, Stat	e, Zıp Code)
re, M l and 2 Health Fitem 2		20a. Method of Disposition 20b. Plac	e of Disposition (Name of cemetery, natory or other place)	Date 20c. Location - City o	r Town, State
Baltimore permit Pages I Department of H Important: If i		4 Donation 5 Other Specify: GREEN	WOOD CREMATORY 10)/05/2006 BROOKLYN,	
Balt permit Depart Import	- 1	21. Signature of the never Here Licensee	22. Name and Address of Facility 8900 REISTERST	SOL LEVINSON & BROOWN ROAD - PIKESVILL	OS., INC. F. MD 21208
Physician /Medical		23a Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	not enter the mode of dying, such as cardia	ac or respiratory arrest, shock, or heart	Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):			Death
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
60, e be executed ysician and burial - transit	ja E	d			
760, icate be emphysician the burial		IF FEMALE: 23c. If yes, outcome of pregnance	erFh,G860, 10/6/06 TT	23d. Date of delive	ry
30x 68760, death certificate be eatending physicifor use as the buri		23b Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of death	2 Fetal death 3 Ectopic pre	egnancy Month	Day Year
P.O. Box that the death c ned by the atten detached for us	Physician	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not result		23e. Did tobacco use contribute to	the cause of death?
P.O. res that the signed by be detacl	2	Commission of the commission o	ing in the underlying cause given in react.	1 Yes 2 No 3 Pro	
ords, aw requir	Completed			autopsy prior to	utopsy findings available completion of cause of
Rec : The Ifficate Page		25. Was case referred to medical	26 Place of Death (Che	performed? death? 1 ✓ Yes 2 No 1 ✓ Y	es 2 No
Division of Vital Records, rat or Attending Physiciau: The law require rs after death al Director: After this certificate has been si led in by the funeral director, page 2 should be	S B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER	[Other:	ursing Home 5 Residence 6 Other	er: Scene
on of veath		(Month, Day Year)	o. Time of Injury 28c. Injury at Work? 03 hrs 1 Yes 2 ✓ No	28d. Describe how injury occurred Subject shot	
Divisic pital or Atte ours after dea eral Directo	Certification:	Suicide Could not be	, farm, street, factory, office building, etc.	28f. Location (Street and Number or R or Town, State)	ural Route Number, City
Di lospital 4 hours a i uneral		4 Momicide determined (Specify) Bar/tavern 29a. Certifier 1 Certifying Physician: To the best of my knowledge, of the control	Naath accurred at the time, data and place	21 South Calvert Street, Balti	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciau: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examination and/o			
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.	October 2, 2006	· · · · · · · · · · · · · · · · · · ·
	-	30. Name and address of person who completed cause of death (Item 23a	2		
V	2		111 Penn Street, Baltimore, MD	21201	
St Regist		31. Date filed (Month, Day, Year) 6 2006 32. Registrar's Signature			

		1	For State Registrar	State of	Marylan		artment <i>rtificate</i>			nd Mental	Hygiei Reg.		5 31612
	sician edical	ı	L O dO y		Ger	Wie	3			2. Date of Month		Day 254 2	3. Time of Death
	miner		a. Facility Name (If not institution,	give street and numb	Gene	rallta	4b. City.	Town, or	Location of C	Death Lmhlo	L	4c. County of E	
Fune Direc			213-01-6923	6. Sex	Age (In yrs.	last birthday) 91 Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min. (Month	f Birth , <i>Day</i> , Ye , 11, 19	ar)	Birthplace (State or Foreign Country) Maryland
Maryland	tor	1	Jsual Residence of Decedent 10a. State 10b. County Maryland	Howard	10c. Cit	y, Town or Lo	cation		olumbia				10d. Inside City Limits
death with the Maryland		1	0e. Street and Number 10850 Green Mount				10f. Zip		2104		10g.	Citizen of What	t Country?
036 ours after rall, or Ite	à	•	Marital Status Never Married 2 Marrie Widowed 4 □Divorced	12. Was Deceding Armed Force of 1 Test 2 If Yes, Give Year or Date	No No		Was Decede f Yes, speci		spanic Origin n, Mexican, F Specify:	n? (Specify Yes o Puerto Rican, etc.	r No-		American Indian, White, etc. White
Vithin 72 ne.	Completed	-	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	s Education grade completed) College (1-4	or 5+)	(Give	dent's Usual kind of work DO NOT use	k done d e retired)	urina most of		16b.	. Kind of Busine	ess/Industry Own Home
The first Hyper doth	Be Be	1	7. Father's Name (First, Middle, La	ast) orge S. Hinkel						Name (First, Mi		den Sumame) her May	
M 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		L	19a. Informant's Name/Relationshi		ndchild		125 Kate	e Wag		or Rural Route Ni Westminste	r, Mary	land 2115	7
Baltimore, permit. Pages 1 a Department of Heel Important: If item			0a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spectrum of Fundamental Service Lieuwart)	ecify)	ate 206. P		natory or oth ohn's Ce	_{her place} emete	ry	Date 10/05/200			ott City, MD
Depart Depart	once		Museul Cuc 23a. Part 1. Enter the disease, or p	Slef 1	1005.	35	3	lack F 871 C	uneral H	lome, P.A. nbia Pike El	icott C	ity, MD 210	
Physici /Medic			shock, or heart failure. List of mmediate Cause (Final disease or condition esulting in death)	a	as a consequ	Se	pt	ا د	S N	rock	ry arrest,		Approximate Interval Between Onset and Death
Examin	e le	3	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying	b	as a consequ	all	en	er	rdl.	fail	ul		
68760, tificate be executed by physicien and as the burial transit	edicai Examiner	t	Dause (Disease or injury hat initiated events esulting in death) Last	c	as a consequ	uence of):	ny	t	ach	er.	ecl	in	
I Records, P.O. Box 68760, The law requires that the death certificate be executed attents been signed by the attending physicien and ages 2 should be detached for use as the burial-transit	Physician/Med	1 4	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		n 2 ∏ Fetal tat time of de	death 3	Ectopic pre					23d. Date of Month	delivery Day Year
rds, P. quires that I am signed by uld be deta	ል		art II. Other significant condition	s contributing to deal	h but not resu	ulting in the ur	derlying ca	use give	n in Part I.				e to the cause of death? Probably 4 Unknown
Division of Vital Records, for Attending Physician: The law requires to effer death. Increment After this certificate has been signed in by the funeral director, page 2 should be a	Completed	-	de	cubil	us	ul	cer			a	Vas an utopsy erformed es 220	prior death	a autopsy findings available to completion of cause of 1?
of Vital Physician: rthis certificated director.	Be	2	5. Was case referred to medical examiner?	Hospital: X.				Otho		Death Check or			
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To	2	1 ☐ Yes 2 ☑ No 7. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of (Month,		ER/Outpatien 28b. Time of Injury		c. Injury Work	4 Nursir			6 ☐Other (S ijury occurred	Specify)
Division To the Hospital or Attending within 24 hours efter death. To the Funerel Director: After	Certification:		3 Suicide 6 Could no determin	t be 28e. Place of	Injury - At ho etc. (Specify	me, farm, stre	eet, factory,			28f. Locatio	n (Street Town, Sta		r Rural Route Number,
he Hospit in 24 hour. he Funere	Medical (H	one)	Physician: To the be kaminer: On the base and manner	s of examinat stated.	tion and/or inv	estigation, i	in my opi	nion, death o	occurred at the tir	ne, date a	ind place, and o	due to the cause(s)
To t To t	Σ	2	9b. Signature and title of certified O. Name and address of person with SUZAN Hock	M			29c.	License	number 087	0	29d. 0	Date signed (MC	onth, Day, Year) Way 29 74
1		3	0. Name and address of person who SUZAN Hood	lo 500	of death (Item	23a) (Type, I	V S	ell	ln.	Clar	usu	ille vi	1021029

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 6 2006

324 legistrar's Signature

			1- For Amend item#15,pe	State of Maryland / DeperFH,G860, 10/6/06 TT Ce	artment of Health and ertificate of Death	Mental Hygier	2 006 31673	
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Melvin Hi			1	30 2006 12:15 P	И
	Examir		4a. Facility Name (Il not institution, give s Baltimove Rehabilital	tion Extended Cave	4b. City, Town, or Location of Deal	th A	Ic. County of Death N/A	
The state of the s	Funeral Director		5. Social Security Number 5. Security Number 6. Security Number 13. Security Number 14. Security Number 15. S	X M 2□F 7. Age (In yrs. last birthday, Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreig Country) MARY LANL)n)
	e Maryland la-f show	ctor	10a. State 10b. County MARYLAND ANNE ARUI	NDEL Co 10c. City, Town or L	-INTHICUM	HEIGHTS	10d. Inside City Limit	
	ath with the	rai Director		ORE FANNAPOLIS BLYL	10f. Zip Code 2/09	10g. C	Citizen of What Country?	
980	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or itame 23e or 28e-f show event, I're Medical Examinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marned 3 ☐ Widowed 4 💆 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: A j ACI IC	
21215-0036	⊆ _ @	Completed	15. Decedent's Educ (Specify only highest grade	College (1-4or 5+) (Give	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	orking	Kind of Business/Industry	
	ould be filed with Mental Hygiene. arked other than atic event, Ire.	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maide	HITING TURNER C. C. on Sumame)	0,
Maryland	od 2 sho lth and 27 Is m	2	19a. Informant's Name/Relationship (Ty)	6 10	ing Address (Street and Number or Ri		r or Town, State, Zip Code) NTH CUM HOHTS MD 210	O _A
Baltimore,	0 0 = 5		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	20b. Place of Disponent State		Date 20c.	Location - City or Town, State	/O
Balti	permit. Page Department Important:		21. Signature of Funeral Service, License	N. Williams	2. Name and Address of Facility B	ROWN JR NAVE.B	FUNERAL HOM.	E 7
	Physician		23a. Part1. Enter the disease, or complishook, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Alzheimers	ter the mode of dying, such as cardial	c or respiratory/arrest,	Approximate Interval Between Onset and Death	
54	/Medical Examiner	er	Sequentially list conditions	Due to (or as a consequence of): Atheros devotic Due to (or as a consequence of):	Cardiovaseul	ar Diseas	e	
oʻ	sate be executed physicien and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
κ 68760,	E 4 5	Medicai	IF FEMALE:					
.O. Box	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
Ω.	quires that I n signed by uld be deta	þ	Part II. Other significant conditions con	ntributing to death but not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death?	n
Records,	The law requir pate has been si page 2 should	Completed				24a. Was an autopsy performed		Э
Vital	Phyeicien: T this certificat ral director, pa	ВеС	25. Was case referred to medical examiner?		26. Place of De	ath Check only one	0 ,12103 22210	
of		ition: To	1 Yes 2 1 No To Add the state of Death 1 Vatural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		dome 5 Residence 28d. Describe how inju		
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, State	and Number or Rural Route Number, te)	1
	To the Hospitel within 24 hours and the Funerel I completely filled	ledical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knowledge, death ner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	a, and due to the cause(surred at the time, date an	s) and manner as stated. Indiplace, and due to the cause(s)	
)	To T To th	Ä	29b. Signature and title of certifier	Wills M M.D	29c. License number 0 4 13 6 5	29d. De Septe	ate signed (Month, Day, Year) ember 30, 2006 more, 11D, 21218	-
	24		30 Name and address of person who con George E, Wick	mpleted cause of death (Item 23a) (Type, \$ M, N, 3900 L	och Raven Boule	vard, Batti	more, MD. 21218	>
***	Sta Registr	/ -	31. Date filed (Month, Day, Year) 0 CT 0 6 200	32 Registrar's Signature	ells			

AMEND ITEM#17, perFH, G861, 11/9/06, WS Please Type or Print in Black indelible Ink. Ensure All Copies Are Legible.

Amend #20bac per FH Good 10/31/00 Jh

State of Maryland / Department of Health and Mental Hygiene Amend item#20c, perFH, G860, 10/6/06 Tertificate of Death Reg. N. 2006 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 12:46 PM Ctober Ε. Harris Audrey /Medical b. City, Town, or Locality

LOCAL PLACE

If Under 1 Year If Under 24 Hrs.

If Under 1 Year If Under 24 Hrs.

B. Date of Birth

(Month, Day, Year)

2/11/1934 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Center Otenvi Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 € F 72 011-26-4721 MA Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County in then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Waldorf MD Charles 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4015 D. #D 20603 TISA Night Heron Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: black δ 3 X Widowed 4 □ Divorced d Hygiene. other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical 12 Nurse other treumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, La Ragland Pages 1 and 2 should be nent of Health and Mental Abraham L. Rogland M. Louise Mansfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Berkeley Street, Boston, Ma 02116 If Item 27 I Debra Anderson / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Unk 20c. Location - City or Town, State Unk. Baltimore, 20a. Method of Disposition 1 Burial 2 Cremation Removal from State 5 permit. Page Depertment of Important: If any injury or once. 10/10/2006 Boston, MA Blue Hill Cemetery | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Survice Licenses 22. Name and Address of Facility harles L. Stevens Funeral Home Inc. 501 East Fort Avenue, Baltimore, MD 21230 -CX 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIO-PULMONARY **Physician** disease or condition resulting in death) /Medical Examiner SCLERDI THERO. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 5 Other (specify) ned by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by ANCER 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No After this certificete has funeral director, page 2: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 10583 31. Date filed (Month, Da), Year) Vi Quasional Signature 320 Registrar's Signature 201095 State parte OCT 0 6 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygien Per ME, C860, 10,057,06dhb Reg. No. 31675 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3 acc Month **Physician** Marcella Evelyn Hershberger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Boonsborg.
If Under 1 Year | If Under 24 Hrs. anrey heed lursing 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace Days Min. 1 ☐ M 2 💢 F 88 Yrs. Maryland Director Apr.12,1918 220-34-0118 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Director Washington Smithsburg Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21783 U.S.A 13404 Greensburg Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after of Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital 4 Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be need of Heelth and Mental Joseph Hamilton Pryor Margaret Anna Fitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 Is any injury or other trai 3421 C National Pike Hancock, Md. 21750 Scott Hershberger (Grandson) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Aug. 26, Smithsburg Crematory Smithsburg, Md. ^¹ 4 □ Donation 5 □ Other (Specify) 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. MO1414 14vis Approximate Interval Between Opset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CONGEST disease or condition resulting in death) /Medical consequence of) Examiner Sequential v list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE esn. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 month 4☐Pregnant at time of death 5 Other (specify) P.O. the ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρλ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 INO 1 Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certification; To 1 Yes 22 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury
(Month, Day Year)
Found
07/08/2006 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Lauvatural 5 Pending Found death. investigation 1 ☐ Yes No Subject fell 2 Accident 1:30 a. 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) hours after de uneral Directo 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Fahrney-Keedy Memorial Home Nursing home 24 hours a Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and

filed (Month, Day, Year) OCT 0 5 2006

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ed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State 27 Manual Am For State Registrar Reg. No. 2 0 0 6 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 14:55 M 200 Henderson Aug Margaret /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Agnes Hospital Battimore Saint If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (St. Month, Day, Year) 9. Birthplace (St. Country) Dec. 18, 1907 Missouri 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 □ M 2 □ F 98 Yrs. Director 217-40-3218 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Maryland Baltimore Catonsville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 709 Maiden Choice Ln. RGT 101 21228 USA Ітепя 23а Peges 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Marned Specify: White Baltimore, Maryland 21215-0036 "netural", or 1 ☐ Yes 2 Ho Specify: þ 3 AWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Beautician Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ie marked William Heiman Rebecca Cora Mullins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health Item 27 Patricia A. Weems (Daughter) 726 Appomattox Rd., Davidsonville, MD 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery permit. Pege Department of Important: if eny Injury or once. 8/17/06 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a Pant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Subdural nematoma weeks disease or condition resulting in death) /Medical Examiner As piration
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Subject fell 1 ☐ Yes 2 No investigation 5:00 p^M 2X Accident 07/19/2006 within 24 hours efter death To the Funerel Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number of Bural Figure Number)
City or Town, State) 4 Homicide ŏ 709 Maiden Choice La., Rgt 101 Assisted Living Facility 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, Hamdallat Aug. 14.2006

State Registrar 31. Date filed (Month, Day, Year) OCT 0 5 2006



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistraAmend #31 Per DVR G860 10/06/Oertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician HARRINGTON MATTIE 0027 AM 2006 007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLUMBIA HOSPITAL HOWARD COUNTY GENERAL HOWARD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sax 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ ¥F Yrs. Director 237-44-2153 Aug 4, 1927 No. Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at 1 TXes 2 TNo Director Maryland Raltimore Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2151 Oak Forest Drive 21043 items 23a USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify 3 ☐ Widowed 4 ☐ Divorced Black "nature!" 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7: h and Mental Hygiene." 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Public School Dietician-Public Schools 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Parker Meta Stroud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an item 27 Helen Harrington Daughter 2151 Oak Forest Drive Ellicott City, Maryland 21043 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of Important: If its eny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/09/06 Jamestown, No. Carolina Carolina Biblical Gardens nature of Funeral Service Ling 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Et brithe disease, of complications that caused the death, shock, dr heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Chase (Final Physician compestive neart disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 15chemie car Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): certificate be executed ettending physicien and for use as the burial-transit atheroscleration resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ete has been signed by the page 2 should be detached 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? livision of Vital Records. 2 STAGE RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy 204 No 1 Yes 2 No 1 ☐ Yes : After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 Inpatient 2 X ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Hospital or Attend within 24 hours after death Jo the Funeral Director: J filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0057177 Oct 05, 2006

State Registrar

DHMH 17 Rev 1/200

21044

Columbia, MD.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Evan Allen English

DCT 0 6 2006

31. Date filed (Month, Day, Year)

			For State Registrar		State of M	-	epartment of Certificate of				giene Reg. W	006	31678
			Decedent's Name	(First, Middle, L.	ast)					2. Date of De		Year	3. Time of Death
	Physici /Medio				icks Sr.					ctobe	er, 5	,2006	7:38a ^M
	Examin	er			ve street and number)		4b. City, Town		of Death			County of Dea	
	Funeral		7591 I			B ge (In yrs. last birth	Dunda day) If Under 1 Yea	r If Under		8. Date of Bir	th	altimo	thplace (State or Foreign
ŀ	Director		212-44-0	364	1 № M 2□F	61 Y	s. Months Day	s Hours	Min.	(Month, Da 3 – 1.6 –			ountry) st Virgini:
	and w		Usual Residence of I	Decedent 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Maryl -f sho lied a	to	MD	Balt	timore	Dund	alk						1 ☐ Yes 2 🔀 No
	d within 72 hours after death with the Maryland piene. r then "natural", or Items 23a or 28a-f show the Medical Examinat must be notified at	Director	10e. Street and Num	ber			10f. Zip Code	1			10g. Citiz	zen of What Co	ountry?
	23a c	ralD	7591 I	ves Lar	ne Apt	B		222			USA		
	er de litems	Funeral	11. Marital Status	ad 20 Married	12. Was Decedent Armed Forces?	?	 Was Decedent of If Yes, specify Co 	f Hispanic Ori Iban, Mexicar	igin? (Spec n, Puerto P	cify Yes or No Rican, etc.))- 1	4. Race - Ame Black, Whit	
920	urs aff	þ	1 Never Marrie 3 Widowed 4	_	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	140	1☐ Yes 2☐N	o Specify:	:				merican
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121	within ene. then "	mple	Elementary/Secon	, , , , ,	College (1-4or	5+)	Sive kind of work don ife. DO NOT use reti borer	red)		3	Cit	ty of	Baltimore
	be filed vital Hygie of other tevent, the		7th 17. Father's Name (F	First, Middle, Las	it)	μa	porer	18. Mothe	er's Name	(First, Middle	, Maiden :		bartimore
lan		To Be	Elmer H	Hicks				Gol	ldie	Vance	9		
Maryland	d 2 should th and Mer ?7 is marke treumatic		19a. Informant's Nar	me/Relationship	(Type, Print) FIAN	19b. M	Mailing Address (Stre	et and Numbe	er or Rural	Route Numb	er, City or	Town, State,	Zip Code)
-	s 1 and 3 (Health item 27 other tr		Shirley		ckson	75	91 Ives	Lane,					and 21222
altimore	ot = ro			Cremation 3 (Removal from State	'	isposition (Name of crematory or other p			ate		cation - City or	
Iţi	그 든 만 근		* 4 □ Donation 5			Green	mount 22. Name and Add	-					,Maryland
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			23a. Part LEnter the shock, or heart	e disease, or oor failure. List on	mplications that cause y one cause on each I	d the death. Do no	t enter the mode of d	ying, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
4	Pnysician	n i	Immediate Cause (F disease or condition		. Ather	rostero	Vc Near	4-6	<u>seas</u>	<u></u>			Onset and Death
	/Medical Examiner		resulting in death)	•		a consequence of							30,
	30.00	-	Sequentially list con- if any, leading to imr	ditions, mediate	D	s a consequence of	perdera						700,3
B	cuted nd ransit	amlner	Sequentially list con- if any, leading to immoduse. Enter Underl Cause (Disease or in that initiated events	ditions, mediate fying njury	Due to (or as		1						20 years
30,0	e executed ian and urial-transit	Examiner	Cause (Disease or in	njury	Due to (or as	s a consequence of	zmla	•					20 years
8760, 2	cate be executed physician and the burial-transit		Cause (Disease or in that initiated events	njury	Due to (or as	s a consequence of	zmla	•					years years
9	certificate be executed nding physician and use as the burial-transit		Cause (Disease or in that initiated events resulting in death) La IF FEMALE:	ast	Due to (or as c. Due to (or as d. 23c. If yes, outcome	s a consequence of s a consequen	2Mla	<u> </u>			2	3d. Date of de	20 years Years
. Box 68760, 29	ath certificat attending phy for use as th		Cause (Disease or in that initiated events resulting in death) La IF FEMALE: 23b. Was decedent in the past 12 n	pregnant nonths?	Due to (or as c. Due to (or as d. 23c. If yes, outcome	s a consequence of sa consequence of	zmla				2	3d. Date of de Month	Jews Vers livery Day Year
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P.O. Box 6	ss that the death certifical gned by the attending phy be detached for use as th	by Physiclan/Medical	Cause (Disease or in that initiated events resulting in death) La IF FEMALE: 23b. Was decedent in the past 12 in 1 Yes 2 Ues 10 Unknown	pregnant nonths?	Due to (or as c. Due to (or as d. 23c. If yes, outcome	s a consequence of s a consequen	3 □Ectopic pregnar 5 □ Other (specify)				obacco us	Month se contribute to	Day Year the cause of death?
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permit. Pages 1 and 2 should be itied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f ahow any Injury or other traumatic event. Its Medical Everth or must be notified at

Baltimore, Maryland 21215-0036

BERNICE

Physicia /Medic Examin

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, 🕆

4	State Registrar							tificate of	Dealli		F	Reg. No.		
	1. Decedent's Name	(First, Middle	e, Last)								2. Date of Dea Month	ath Day	Year	3. Time of Dea
1	Berne	ice El	izabe	th Hi	11						CETUBE	-		6:121
r	4a. Facility Name (If not institution, give street and number) GOOD SAMARI TAN HOSPY					•		4b. City, Town, or Location of Death BAZTIMORE			4c. County of Death			
	5. Social Security N 219-20-81	46	6. Sex 1 □ N	4 2 🖟	7. Age (II		birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birt (Month, Pa July	1926	9. Birthi Cou Mar	place (State or Foi ntoy) y Land
}	Usual Residence of 10a, State	10b. County	,		10	0c. City, T	own or Lo	cation						10d. Inside City Li
5	Maryland Carroll					Hampstead				1 ☐ Yes 2 💆				
ecc	10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?					
Funeral Director	4420 Black Rock Rd. Apt. 8					21074				U.S.A.				
Jera	11. Marital Status 12. Was Decedent Ever in				er in U.S.	13.	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric		cify Yes or No-	14. Race - American Black, White, etc				
2	1 Never Married 2 Married 1 Yes, 2 Mo 1 No Hydroged 4 Divorced Year or Dates:				1 ☐ Yes 2 ☑ No Specify: Specify:									
Completed	15. Decedent's Education (Specify only highest grade completed)					1	16a. Decedent's Usual Occupation (Give kind of work done during most of working) 16b. Kind of Business/Industry					ndustry		
du l	Elementary/Secondary (0-12) College (1-4or 5+)					Screener					~			
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Be	17. Father's Name William			nock							Lillia			
2							19b Maili	na Address /Stree					J.	p Code)
ĺ	19a. Informant's Name/Relationship <i>(Type, Print)</i> Blanche Caudill — sister						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4151 Smithton Dr., Manchester, Md. 21102					/		
	20a. Method of Dis		No			20b. Plac	e of Dispo	sition (Name of			Date	_	cation - City or T	own, State
	r Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)						boro	matory or other pl Union Ce	em. Oc	-				
	21. Signature of Fi	uneral Service	Licensee				E8	Name and Add 196 Charr	Funera nil Dr	Y Ch . Ma	apel P. ncheste	A. r, Mo	d. 2110	2
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** James Eden Hass 2, 2006 October 0 7:13A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 561-84-7594 53 Dec. 14, 1952 Ohio Director Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland | Montgomery Chevy Chase 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or Funeral 4832 Langdrum Lane 20815 United States "natural", or items dical Exa⊓iner m 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No 2 Specify: 3 Widowed 4 Divorced White Completed event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Law and Economics al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Financial Consultant Consulting Group 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If Item 27 is marked of any Injury or other traumatic eve Harold William Hass ဂ Dorothy Eden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4832 Langdrum Lane, Chevy Chase, Maryland L. Sue Andersen/Wife 20815 saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State October 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Prium, Inc. 8, 2006 Bethesda, Maryland

22. Name and Address of Facility Robert A. Fumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction Minutes /Medical Due to (or as a consequence of) **Examiner** Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical attending ph I for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 I Inknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 🔲 Inpatient 2 X ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D50300 October 3, 2006 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 6

9801 Georgia Avenue, #116, Silver Spring, Maryland

M.D.

32. Registrar's Signature

ORIGINAL

Thomas J. Anthony, 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Amend #5 Per FH G860 10/06/06 Department of Health and Mental Hygien [2] 0 6 Figure 10 Per FH G860 10/06/06 Department of Death Reg. No. 31681 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 Year **Physician** 21, Joan Gertrude Haase September 3:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 107 George Street Chesapeake City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Yrs. Director 61 13, 1945 Mass. March Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itama 23a or 28a-f ahow the Medical Examiner must be notified at Y☐Yes 2☐No **Funeral Director** Md. Ceci1 Chesapeake City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 George Street 21915 USA be filed within 72 hours after death intal Hygiene. Id other than "natural", or Itama 23s Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Restaurant permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy important: If item 27 is marked other any injury or other traumatic avent. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Casimere Sulecki Gertrude Pivenski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John R. Haase, Sr., Husband 107 George St., Chesapeake City, Md. 21915 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co, 9/28/06 West Chester, Pa. 21. Sig ature of Planay 13 rvice Licensee 22. Name and Address of Facility 259 E. Main St., Andrew G. Gee F.H. Elkton, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CVA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificete has 2 🗆 No 1 Tyes 1 Yes 2√ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Statement 6 Other (Specify) 1 Yes 2 No Siu 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) In cee Ha MI) DO 4823 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) west mai St, E/Ktor Md 2/92/ 3 MD 22 3 CHIH 1484 31. Date filed (Month, Day, Year) SEP 2 5 32. Registrar's Signature State Registrar

06-07430 Billy J. Horne Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

•			1- For State Certificate of Death Registrar		Reg. No. 200	6 3 682
Physic edical Exar		44	1. Decedent's Name (First, Middle,Last) BILLY J. HORNE	2. Date of Dea Month October 2	ath Day Year 2 2006	3. Time of Death 0638 hrs
			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location		4c. County of Deal	
Funera		4	Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	ler 24Hrs. 8 Date of B	irth(MM/DD/YYYY) 9. Bi	
Directo			219 70 0760 1X M 2 F 47 Yrs Months Days Hours		Fore	
any		ŀ	Usual Residence of Decedent 10a State			10d. Inside City Limits
Maryland	once,	ট্	MD. N/A BALTIMORE			1 Xres 2 No
the Mary	tified at	Director	10e. Street and Number 3867 LYNDALE AVENUE 10f. Zip Code 21213		10g. Citizen of What Cou USA	untry?
72 hours after death with the Maryland "n"natural", or items 23a or 28a-f she	nust be n	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican		o- 14. Race - Ame White, etc.	rican Indian, Black,
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21215-0036 Juld be filed within 7 Mental Hygiene marked other than	the Me	S	17. Father's Name (First, Middle, Last) 18.Mother	r's Name (First, Middle,	Maiden Surname)	
2121 uld be fi Mental I		o Be	RICHARD HORNE ANNI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nur	IE WILLIA		e Zin Code)
MD :	umatic		GINA HORNE / WIFE 3867 LYNDALE AV			
Baltimore, MC permit Pages 1 and 2 s Department of Health a important: If item 27	other traumatic		20a Method of Disposition Second	Date OCT . 10 , 2	20c. Location - City o	
Baltimo permit Page Department o	injury or	1	21 consture of Funeral Service Licensee 2 Name and Address of Facility ALVIN B. SC	RUGGS FUN	ERAL HOME	
Physicia	n		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death.	PON ST B cardiac or respiratory ar	rrest, shock, or heart	21213 Approximate Interval Between Onset and
/Medica ≒xamine	-	ı	Immediate Cause (Final disease or condition resulting in death) a. Multiple shotgun wounds Due to (or as a consequence of):			Death
	ı		Sequentially list conditions, b			
		iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
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OX 68 ath certif	for use as	/sician	past 12 months? 1 Live birth 2 Fetal death 3 Ectopi 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ic pregnancy	Month	Day Year
O. Be hat the de ed by the	etached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.		tobacco use contribute to	
rds, P.C requires that been signed	nld be		-	1Ye	es 2 No 3 Pro	obably 4 Unknown utopsy findings available
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on of ending Pl ath or: After	the fune	tion:	1 Natural 5 Pending Oct 2, 2006 0605 hrs 1 Yes 2	Subject ships		
Division of Vital F the Hospital or Attending Physician: hin 24 hours after death the Funeral Director: After this certifi	led in by t	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Outside dwelling	or Town,	(Street and Number or R State) ale Avenue, Baltim	
the Hospital		Medical Co	29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and plone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	lace, and due to the cau	use(s) and manner as sta	arted
To the within To the	compl	Med	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (M	
/1			Theodor M. Fring JR., mul. O.C.M.E.		October 3, 2006	5
4			Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD.	altimore, MD 2120	01	
	Sta	ate	31. Date filed (Month, Pay Year) 2006 32 Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician Nancy Ann Huting** 11:30 p.mM October 1, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catonsville Baltimore 719 Maiden Choice Lane; Apt. BR441 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 ☐ F Director 79 214-22-7168 August 29, 1927 New York Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code With 21228 U.S.A. Iteme 23a 719 Maiden Choice Lane; Apt. BR441 by Funeral Pages 1 and 2 should be tiled within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify. White 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Education Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Math Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be t of Health and Mental If Item 27 is marked o Dorothy M. McRoy ဥ William Wallace Dulton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Circle Rd. Pasadena, Maryland 21122 Mr. Dale K. Huting, Jr. other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If Ite
eny Injury or ott 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 10/04/2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) **Bayyiew Crematory** 21. Signature of Fune al Service Licensee 22. Name and Address of Facility undulla Slack Funeral Home, P.A. 140053 3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final **Physician** disease or condition resulting in death) 0 month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2X No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perfos 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes (No Certification: To Atter thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certified of death (Item 23a) (Type, Print) Timureo 31. Date filed (Month, Day. 32. Aegistrar's Signature State 2006 Registrar

Amend Item 3, State of Many 1880 Opp And Propagation and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** 11:30 Annie E. Johnson Aug 9, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore** 6000 Morvia Park Drive Apt C1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1 M 2 F Director 212-22-2449 80 Mar 17, 1926 Md Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28e-f show 7 is marked other then "natural", or Items 23a or 28e-f shov treumatic event, the Mudicul Examination until to mutified at 1 X Yes 2 □ No Director Md **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 6000 Moravia Park Drive 21206 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Itel 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify þ Specify Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) mestic oneMAKER 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Russell Johnson Harriett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy Alexander Nephew 6000 Moravia Park Drive Apt C1 Baltimore, Md 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial /2 Excremation 3 Reproval from State injury or permit. Page Department of Importent: If any injury or once. 08/14/06 MD 4 Donation /5 Other (Specify) **Bayview Crematory** 21. Signature of Funeral Service Linensee 22. Name and Address of Facility Miller's Metropolitan Chapel P.C. 1639 North Broadway Baltimore Maryland 21213 or combications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, ist only one cause on each line. 23a Part1. Enter the Approximate Interval Between Onset and Death hock, or heart ailure I ist onl Immediate Cause (Final sease or cond) on resulting in deat) Priysician YEARS DEMENTIN /Medical APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Examiner STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PLETURE SEIZURE DISORDER 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel t 🖟 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUGUST 15, 2006 D62032 30. N = e ani addrest of person who completed cause of death (Item 23a) (Type, Print) 5505 HOFKINS BATVIEW CIRCLE, BALTIMORE MD HAYASHI ENNIFER 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 4 2006 Registrar Acorp. DHMH 17 Rev 1/2001

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			For State Registrer	State of Ma	ryland		artmen rtificat			and M	ental Hy	gien	e 2nne	-	31685
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Physic /Medi		AGENORA WILS	ON LEE					r 30 2006	8:17a ^M
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and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
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h with		1040 E 33rd St.	# 211		2121	8		U.S.A.	
deat	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of H		ecify Yes or No-	14. Race - Ame Black, Whit	
ife, INTAINITATION ZIZIO-UUSO s 1 and 2 should be filed within 72 hours after death with the Marylan if fealth and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow other treumatic event, Ina Medical Examinar Iranal te mytified at	þ	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📆 No If Yes, Give Year or Dates:	•	1 ☐ Yes 2 🂢 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: BLA	
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DESILITIONS permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licer			22. Name and Addre WILLIAM C	ss of Facility	_		
2 00240		22a Part Enter the disease or com	plications that caused	the death. Do no	1206 W NOR				21217 Approximate
		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	-			ig, such as cardiae	or respiratory arre		Interval Between Onset and Death
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IS, P.O. BOX of the standard that the death certified by the ettending be deteched for use a	by Physician/M	23b. Was decedent pregnant in the past 12,months?	23c. If yes, outcome of 1□Live birth	Fetal death	3 Ectopic pregnanc	y		23d. Date of de Month	livery Day Year
the e	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t 9☐ Unknown	ime of death	5 Other (specify)				
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d be					, ,		1 □ Ye	s 2 [°] Dowio 3⊟P	robably 4 Unknown
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VITAI HECORDS, P.O. siclen: The law requires that the certificate has been signed by the irector, page 2 should be deteched.	Completed						autops	y prior to ned? death?	completion of cause of
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DIVISIO To the Hospital or Atlandi within 24 hours effer death. To the Funeral Director: A completely filled in by the the	Medical	one)	miner: On the basis of and manner sta	examination and ted.					
To t To t	Σ	29b. Signature and title of certifier	11,	h	29c. Licen			9d. Date signed (Mon	
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5		30. Name and address of person who	15-	ath (Item 23a) (Type, Print)	C2 C	./ 11	ng T	, 2006
		31. Date filed (Month, Day, Year)	32 Règistra	r's Signeture	h Charles	51,50	vir de	11, 104	Ou 190 2120
St Regis	ate trar	C 7 6 20	06	r's Signature	Goods				

		1	For State Registrar		State of	Maryland		artmen <i>rtificat</i> e				ental Hy	/gien Reg. N	200	6	31687
			1. Decedent's Nam	ne (First, Middle,	Last)							2. Date of D		ay	Year	3. Time of Death
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	Funeral Director		5. Social Sectrity I	5382	3. Sex 7 12XM 2□F	7. Åge (In yrs. la	ast birthday, Yrs.	If Under Months	Days	Hours	Min.	8. Date of B (Month, D 08/2	irth Pay, Year 1/1 9:	^{r)} 34	9. Birthpla Counti	ace (State or Foreign ry) VA
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<u>ta</u>	icien: Th certificate rector, pag	BeC	25. Was case refe	erred to medical						26. Plac	e of Death	(Check only		NO		20 100
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<u>0</u>	ding Physicien: The lav h. After this certificate has funeral director, page 2	n: T	27. Manner of Dea	ath 5 ☐ Pending	28a. Date of (Month	f Injury n, <i>Day Year)</i>	28b. Time o	of 2	8c. Injur Wor	y at k?	2	8d. Describe	how inj	jury occurre	ed	
<u>.0</u>	Attendir death. ctor: Af y the fu	atic	2 Accident	investiga	ation			М		Yes 2						
	or Att after d Direct In by I	Certification;	3 Suicide 4 Homicide	dotomic	and 280. Place	of Injury - At ho ig, etc. <i>(Specif</i> y	me, farm, s	treet, factor	y, office		2	28f. Location City or T	(Street a own, Sta	and Numbe ate)	or Or Rurai	l Route Number,
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier (Check only		Physician: To the I											
	within 2-	Medical	one) 29b. Signature ag	rd title of certifier	and manne	er stated.		29	c. Licens	e number			29d. C	Date signed	(Month, L	Day, Year)
	- 3 + ö		Min	pmax	Bern	e mi	2		80	155	4			9/27	1/06	
_			30. Name and add	dress of person w	no completed cause	of death (Item	23a) (Type	Print) DR11	bon	d k	Com	PAO	X	150.7	60	
	Sta	te	31. Date filed (Mo	onth, Day, Kear)	39. Re	egistrar's Signa	ture	, and y	W/L		WOR	juic	/ 1	The C	~	
	Registr		00	CT 0 5 20	106	معرض مديحة	1920	alis y								

			For State	State o	f Maryla		artment of H		nd Me	-	-211115	31688
			Registrar 1. Decedent's Name (First, Middle, La	st)			imodio or E	Journ	2.	. Date of Death	. Nó 0 0 0	3. Time of Death
П	Physici		Anthony L	600	GINA				-	Month	Day Year	6 9:00 M
)	/Medio Examin		4a. Fecility Name (If not includion, giv				4b. City, Town, or	Location of		Cioper	4c. County of Dea	
	Exami			-D North C	7	Road			Ellico	tt City		Howard
	Funeral		5. Social Security Number 6. S	ex		s. last birthday)	If Under 1 Year Months Days	If Under 2	Min. 8.	Date of Birth (Month, Day, Y	9. Bir	thplace (State or Foreign
	Director		090.03.8571	2 F		95 Yrs.	Months Days	Hours	Min.	May 10,		New York
	pu .		Usual Residence of Decedent 10a. State 10b. County		100 0	City. Town or Lo				way 10,	1011	T
	aryla ehov	ž			100. 0	ony, rown or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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	within 72 hours after deeth with the Maryland ene. than "naturel", or items 23s or 28s-f ehow he Modical Exeminar must be notified at		3341-D North Chatha	m Dead			10f. Zip Code	210	042	109		J.S.A.
	ns 23	Funerai	11. Marital Status		edent Ever in	U.S. 13.1	Was Decedent of His			v Yes or No-	14. Race - Amo	
	ter d	Fun	1 ☐ Never Married 2 ☐ Married	Armed Fo	rces?	0.0.	Was Decedent of His If Yes, specify Cubar	n, Mexican,	Puerto Rio	an, etc.)	Black, Whi	
3	"naturel", or	ģ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gir Year or D	ve		1 ☐ Yes 2 ☐XNo	Specify:			Specify:	White
21215-0036	72 ho	Completed	15. Decedent's E				dent's Usual Occupa kind of work done d		of working	16	b. Kind of Business	/Industry
7	thin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,)	-		NYC Tra	ansit Authority
	s filed within the street than the street than sent, the sent.	Co	12				Sta	tion age				
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<u>\sqr</u>		٩		ıy LaRegir	na						eresa Carruo	
Maryland			19a. Informant's Name/Relationship (•							City or Town, State,	Zip Code)
	1 an Healt em 2 ther		Mr. John Castellan 20a. Method of Disposition	o So	on in law	Place of Dispo	9060 Bellwart	vvay C	Olumbia		c. Location - City or	Town State
Baltimore,	Set		1 ☐ Surial 2 ☐ Cremation 3 ☐			cemetery, crer	natory or other place	9)				
			4 Denation 5 Other (Special 21. In gratual of Funeral Service Lice)		/	10000000	John's Cemete . Name and Addres	-	NI TRANSPORT	7/2006	NON	walk, CT
g	permit. Departr Imports eny inje		Calle weller	141	- MAN	2532	Slack I	Funeral	Home.	P.A.		
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that			er the mode of dying	old Colu g, such as c	imbia Pi cardiac or re	ike Ellicott espiratory arrest	City, MD 2104	Approximate
	Physician		Immediate Cause (Final	one cause on e								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. COR	or as a conse	coverce of):	rtery	D13	645	.6		10 years
	Examiner				(0. 40 4 001100	463,000 017)					Ü
Н		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that inifiated events	Due to	(or as a conse	equence of):						
	ansi a	Examiner	Cause (Diseese or injury that initiated events	c								
Š	e exe ian a urial-1	Ĕ	resulting in death) Last	Due to	(or as a conse	equence of):						
8/60	ficate be executed physician and is the burial-transit	dicai	•	d								
0	ertific ding p	0	IF FEMALE:	02- 16								
X R R	eath certifii attending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?		ointh 2 🗆 Fe	tal death 3	Ectopic pregnancy				23d. Date of de Month	livery Day Year
o.	law requires that the death certifi es been signed by the attending 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐ Pregr 9⊡ Unkn	nant at time of own	death 5	Other (specify)					
2	that the ded by detac	F.	Part II. Dther significant conditions	ontributing to d	eath but not re	esulting in the u	nderlying cause give	n in Part I.		23e. Did tobac	cco use contribute to	the cause of death?
Vital Records,	uires sign ld be	d by								1 ☐ Yes	2 No 3 P	robably 4 Unknown
င္ပဲ	w require been si should l	lete								24a. Was an	24h Were a	utopsy findings available
ě	The la	Completed								autopsy performe	d? prior to death?	completion of cause of
g		ပိ	25. Was case referred to medical					26 Place	of Doath //	1 ☐ Yes 20 Check only one)	No 1 □ Yes	2 □ No
	Physician: r this certific ral director,	0 B	examiner?	Hospital:	Inpatient 2[☐ ER/Outpatien	t 3 DOA Othe				ce 6 Other (Spe	crifu)
ō	g Ph er thi	ī.T	27. Manner of Death	28a. Date		28b. Time of				. Describe how		ony/
<u></u>	Attending or death. ctor: After by the fune	atio	1 Pending 2 Accident investigatio		(II, Day 1991)	Injury		r ′es 2 □ N	lo			
DIVISION	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place	of Injury - At	home, farm, str	eet, factory, office		28f	Location (Street City or Town, S	et and Number or R	ural Route Number,
5	rs aft e Dia	Cer					_					
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	cai	(Check only 2 Madical Exal	niner: On the b	asis of examir	nowledge, death	occurred at the tim	e, date and inion, death	l place, and	due to the caus	se(s) and manner as	s stated.
	the 2 the mplet	Medical	one) 29b. Signature and title of certifier	and man	ner stated.							
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	(1		William He	ころとう	ni	20 m 02 m	Doint)	121	l	00	rober 4	2006
	8		30. Name and address of person who	completed caus いと によ,	or death (Ite	em 23a) (1ype,	-) HoV	4111	Cat.	- Colum	nh.	ne
	Sta	te	31. Date filed (Month, Day, Year)	32. F	legistrar's Sign	nature 13	Acorto a	, 10 X	C-1	7107	1.219	- 1-5
	Registr		OCT 0 6	2008	LAS AGE	· Sign	A STATE OF THE STA				to ber 4	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 06, 2006 5:35 A. M Carl Thomas Musser /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore County Towson Gilchrist Center 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1X7 M 2 □ F Director 215-48-5673 61 08,1945 Baltimore, MD. Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show diral Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore County Monkton Maryland| 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death with United States 21111 by Funeral 3962 Old York Road 12. Was Decedent Ever in U.S. Armed Forces? 1½ Yes 2 □ No If Yes, Give Year or Dates:Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 Is marked other this any Injury or other traumatic event, the once. Trucking 10 Truck Driver n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virginia DeBoard Frank W. Musser ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 Jarrettsville, Maryland Mrs. Judy M. Zanotelli(Sister) 2409 Lemon Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 □Removal from State Evans Funeral Chapel Oct.07,2006 | Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice/see 22. Name and Address of Facility Peaceful Alternatives Funeral&Cremation Ctr., P.A 21093 2325 York Road Timonium, Maryland 23a. Parth. The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Small cul Physician months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performad? 1∐ Yes 2 🗖 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Apther (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

within 24 hours a To the Funeral L

State Registrar

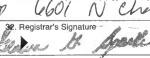
(Check only

29b. Signature and title of certifier

Amor w Charles 31. Date filed (Month, Day, Year)

OCT 0 6 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Charles St Boronne un 21204

29d. Date signed (Month, Day, Year)

October 6 2006

Please Type or Print in Black Indelible lnk

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Michael Anthony McQueen	State of Maryland / Department of Health and Mental Hygiene
1- For State	Cortificate of Dooth

7245 ael Anthony	Mc	Please Type or Print in I		vaiono
aei Antilony		Queen State of Maryland / Department of 1- For State Certificate of Registrar		Reg. No. 2006 3169
Physicia ical Exami	an/			2. Date of Death Month Day September 26, 2006 3. Time of Death 0100 hrs
)		4a. Facility Name (if not institution, give street and number) 414 N. Summit Apt 202	4b. City, Town, or Location of Death Gaithersburg	
Funeral Director		5. Social Security Number 589-59-3487 6. Sex 1. Age (In yrs. last birthday) 22 Yrs	If Under 1 Year If Under 24Hrs Months Days Hours Min	1
ith the Maryland 23a or 28a-f show any notified at once.	tor	Usual Residence of Decedent 10a. State	New Orlea	10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country?
h the Mar 13a or 28a totified at	Director	416 Vallette Street	10f. Zip Code 70114	United States
DARLITIOTE, NID ZIZIO-UOJO permit Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 X Never Married 2 Married Armed Forces? If Y	is Decedent of Hispanic Origin? (Sies, specify Cuban, Mexican, Puerto Yes 2 X No specify:	
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Pages 1 and 2 should be filed within 72 hours after death wiment of Teatht and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be	Be	17. Father's Name (First, Middle, Last) Michael A. McQueen	Glenda	e (First, Middle, Maiden Surname) a Kay Wright
d 2 should the and M	2	Glenda Kay McQueen/Mother 416	Vallette Stre	Rural Route Number, City or Town, State, Zip Code) Pet, New Orleans LA 70114
Pages I an ment of II ea tant: If ites or other tra		1 Burial 2 Cremation 3 X Removal from State Arlingto		Date 20c. Location - City or Town, State em 10/7/06 Arlington VA
permit Departr Import injury		21. Signature of Funeral Service Licensee Victor Doda Charles 150	lame and Address of Facility arles L. Steve 01 E. Fort Ave	ens Funeral Home, Inc. e, Baltimore MD 21230
hysician /Medical xaminer	Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		Between Onset and Death
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e death certificate be the attending physici ed for use as the buri	ysician/Med	past 12 months?	etal death 3 Ectopic pregnate the control of the state of	ancy Month Day Year
w requires that the d as been signed by the should be detached	d by Phy	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
B 2 (7)	Completed			24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
sician: The is certificate irector, page	Be	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpatient	26.Place of Death (Check	only one) ng Home 5 Residence 6 ✔ Other: Scene
ling Physician: The Land After this certificate funeral director, page	on: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of I	njury 28c. Injury at Work?	28d. Describe how injury occurred
To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident 3 Suicide 6 Could not be Pending Investigation Fnd 9/26/2006 Fnd 12:5		subject shot 28f. Location (Street and Number or Rural Route Number, City or Town, State) 414 N. Summit
To the Hospits within 24 hour To the Funera completely fill	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investigation.	rred at the time, date and place, and tion, in my opinion, death occurred	Gaithersburg, MD d due to the cause(s) and manner as started at the time, date and place, and due to the cause(s)
To with	Mec	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) September 27, 2006
		30. Name and address of person who completed cause of death (Item 23a)		
St	ate	31. Date filed (Month, Day Year) 32 Kegistrar's Signature	Street, Baltimore, MD 2120)1
Regist	rar	OCT 0 5 2006		

			For State Registrar	State o	of Maryla		artment of				ene g. No. 0 (36	31691
	Dhuaiai		Decedent's Name (First, Middle,	Last)					2. [Date of Death)	Year	3. Time of Death
	Physicia Medic/		Donald McBride						0c	tober	4 ^{Day} 200		4:15AM ™
)	Examin	er	4a. Facility Name (If not institution, Gilchrist Cente	-	mber)		4b. City, Town, TOWS		of Death		4c. County	timor	re
F	uneral			3. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under	Min (Date of Birth Month, Day,			place (State or Foreign ntry)
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land	MON III		10a. State 10b. County		10c. (City, Town or Lo	ocation					1	10d. Inside City Limits
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with th	B or 2	Funeral Director	10e. Street and Number	Doad			10f. Zip Code	204		10	g. Citizen of V US		itry?
death	ma 23	nerai	1055 West Joppa	12 Was Dec	edent Ever in	U.S. 13.	Was Decedent of If Yes, specify Cul		igin? (Specify	Yes or No-	14. Rac	e - Americ	can Indian,
:1215-0036 within 72 hours after death with the Maryland ene.	or ite	y Fur	1 Never Married 2 Marrie	If Yes, Gi	2 □No Wi ive	WILL	ir res, speciny Cui 1 □ Yes 2\UX No			n, etc.)	Specify	ck, White, v: Whi	ite
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Mary 12 sho h and !	7 ie marraume		19a. Informant's Name/Relationsh Donald McBride		Son		ng Address <i>(Stree</i>				-		inia 22314
Te, T	tem 2 other		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of		π±303 Date		Oc. Location -		
Pages Pages	nt: If i		1 ☐ Burial 2 XX remation ↑ ☐ Donation 5 ☐ Other (Sp		State		natory or other pla nt Crema		10/5/06	В	Baltimo	re, N	Maryland
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of Vital Physician:	rthis c raldire	-: T	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 🗆		ER/Outpatier	IL SLIDON		ursing Home 28d.		nce 6 TOth		y) tospice
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Divis	I Directo d in by th	Certification:	3 Suicide 6 Could n 4 Homicide determin	289. Place	e of Injury - Al ling, etc. (Spec	home, farm, sti cify)	reet, factory, office			ocation (Stre City or Town,		er or Rura	il Route Number,
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To th	To the	¥.	29b. Signature and title of certifier	. /	0			ise number	15		d. Date signed		
			1/1 Hast	my 1	M	- 22-12	De Do	J de	0.7	1	ctob	en 4	, 2006
	15		30. Name and address of person v	Smc	6 70 (өн 23a) (Тура,	learle.	St.	Bala	s. m	14 2	(20	£ 2006
	Sta Registr		31. Date filed (Month, Day, Year)	006	Registrar's Sig		MARI J						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 6 6

31692

		•	1 = For State Registrar		- ylana / c	•	tificate			violitai i i	Reg. No.		
ı	Physici	an	1. Decedent's Name (First, Middle, Las Robert Mitchell	t)						2. Date of D Month 09	eath Day 29		3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give Prince George's H				4b. City, To		cation of Death		4c.	2006 County of Death	
	Funeral Director		372-20-4470	ex 7. Age	(In yrs. last bir 82	thday) Yrs.	If Under 1 Months		Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	irth ay, <i>Year)</i> 1924		hplace (State or Foreign untry) thigan
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow Washir								10d. Inside City Limits 1
	th with the 23a or 28	Funeral Director	10e. Street and Number 725 24th Street N	. W.			10f. Zip C				10g. Citi	izen of What Co	untry?
980	be filed within 72 hours after death with the Maryland stal hygiene. od other then "nature!', or terms 23a or 28a-f show event, the Mexircal Examinar must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ★ Divorced	12. Was Decedent Endemed Forces? 1 ⊠ Yes 2 □ Note of Yes, Give Year or Dates:		1	Vas Deceder fYes, specify □ Yes 2		anic Origin? (Si Mexican, Puerti Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - Ame Black, White Specify: Wh	e, etc.
15-0	in 72 ho	Completed	15. Decedent's Ed (Specify only highest grad	de completed)		(Give	lent's Usual kind of work OO NOT use	done duri	n ng most of wor	king	16b. Ki	ind of Business/	Industry
212	e filed within al Hygiene. Other then "	Com	Elementary/Secondary (0-12)	College (1-4or 5+ 4+		tor	ney					omobile	
land	should be fill nd Mental H marked oth	To Be	17. Father's Name (First, Middle, Last) Unknown						i. Mother's Nan Unknowr	ne <i>(First, Middl</i> e 1	e, Maiden	Sumame)	
Maryland 21215-0036	d 2 sh th and th and 17 ie m treum	-	19a. Informant's Name/Relationship (7 Dolores Prins/Fri									DC 2003	
Baltimore,	Pages 1 an nent of Heal nnt: if item 2 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of cemete.				y 10-5	Date 5-2006		sville,	
Balti	permit. Pages 'Department of Pimportant: if ite eny injury or of once.		21. Signature of Funeral Service Licen	2 no	358	Ra	Name and pp Fur	Address oneral	& Cren	Silver nation S	Spr Svc93	ing,MD 3 Gist	Ave20910
68760,	Physician per percentage as the burial-transit as the burial-transit	ledicai Examiner	shock, or heart failure. List only of the state of the st	ease or condition sulting in death) Quentially list conditions, iny, leading to immediate use. Enter Underlying use (Disease or injury to initiated events Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									Approximate Interval Between Onset and Death
.O. Box 68	death cer e attendin id for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death		Ectopic preg Other (spec					23d. Date of deli Month	ivery Day Year
S, D	quires that n signed b uld be deta	ል	Part II. Other significant conditions co	ontributing to death but	not resulting i	n the ur	nderlying cau	use given i	n Part I.		tobacco u		the cause of death?
Vital Record	. The law requires that the sate has been signed by the page 2 should be detache	Completed								24a. Wa auto peri 1 Yes		prior to death?	topsy findings available completion of cause of
Vita	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatien	t 2) ER/O	utnation	t 3 DOA	Othor		ath (Check only		6 □Other (Spec	2.6.1
ion of	of feel	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		Time of Injury		c. Injury at Work?		28d. Describe			J. 197)
Division	To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, fa (Specify)	arm, str	eet, factory,	office			(Street an own, State		iral Route Number,
	he Hospil in 24 hour he Funer pletely fills	edical	29a. Certifier (Check only one) (Check only one)	ysician: To the best of niner: On the basis of and manner stat	my knowledge examination ar ed.	e, death	occurred at restigation, in	t the time, n my opini	date and place on, death occu	, and due to the rred at the time	cause(s) , date and	and manner as diplace, and due	stated. to the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier	1000	mi	٨	29c. 1	License n)			te signed (Monti	
7	\cap		30. Name an tress of per who o		/ /	(Туре,	Print)	V V	101			10-3- D 201	06
10		10	31. Date filed (Month, Day, Year)	300) 32. Registral	r's Signature	ITAZ	DR.		U	HEVERLY	1, M.	0 201	25
	Sta Regist		OCT 0 6 2	006	E M	A	noch p						

State of Maryland / Department of Health and Mental Hygieney 31693 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Marie Morel September 27, 2006 4:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville

If Under 1 Year | If Under 24 Hrs.

MonIhs | Days | Hours | Min. Montgomery 773 Azalea Drive 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 □ F 80 Yrs. 067-76-9848 Haiti Director Jan. 18. Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f ehow 1 X Yes 2 No Rockville Directo Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r then "natural", or items 23s or I've Medical Examiner must be 20850 77<u>3 Azalea Drive</u> United States Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene important: if Item 27 ie marked other then "natural, or Item eny injury or other traumatic event, If a Medical Example once. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Placid David Lamercie Taylor-Pere ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Louise M. Jackson/Daughter 773 Azalea Drive, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 7, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Montgomery Crematorium Bethesda, Maryland 2006 Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850 21. Signature of Funeral Service Licensee M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Months Ischemic Cardiomyopathy /Medical Examiner Aortic Valve Replacement Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) burial-Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part If, Other significant conditions contributing to death bul not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cutaneous T-cell Lymphoma 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 1 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 X No ٩ 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 28d. Describe how injury occurred Certification: After 1 XNaturaf 5 Pending To the most after death.

Vithin 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) ۽ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0035045 September 28, 2006 o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

State Registrar

D

31. Date filed (Month, Day, Year) OCT 0 6 2006



DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2006 31694 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death OCTOBER 5, 2006 4:00 A. M **Physician** MARY Μ. **MEYERS** Year /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner OAKCREST CARE CENTER PARKVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10-15-1912 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 □ M 2/XF 216-24-0686 93 Yrs MÄRYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehov the Medical Examiner must be notified at PARKVILLE 1 Yes 2XXVo MD. BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21234 8832 WALTHER BOULEVARD, #307 NORTH U. S. A. 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes Ā(Ā) No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes XX No Specify: WHITE δ Specify: XXWidowed 4 □ Divorced "nature!" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0·12) 12 YEARS College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: if Item 27 is marked oth eny injury or other traumatic event QDEs. Be **JOHN** Τ. KELLY MARY DONALDSON ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRIC B.MORRISON (SON) 401 BLUMRIDGE COURT, #302, LUTHERVILLE, MARYLAND, 21093 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial XX Cremation 3 ☐ Removal from State 10-06-2006 TOWSON, MARYLAND, 21204 HILLTOP SERVICE CORP. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. (R. G.RUTH) TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Prev monica **Physician** DAYJ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 pronths?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 walth morner 32. Registrar's Signature 31. Date filed (Month Car Year) 2006 State Registrar

Meyers, many

State of Maryland / Department of Health and Mental Hygien [9] [] [5] For Stata Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death oct. 3, 2006 Year **Physician** EVE MARKS 3:13 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE 1500 BEDFORD ROAD #511 If Under 1 Year Months Days Birthplace (State or Foreign Country) RUSSIA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 0471171 907 1 □ M 2 🛛 F 218-30-7440 99 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show Pages 1 and 2 should be filed within 72 hours elter death with the Marylar nent of Heelth and Mental Hygiene.
ant: If Item 27 is marked other then "neturel", or Items 23a or 28a-1 ehov ury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No BALTIMORE BALTIMORE Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1500 BEDFORD ROAD #511 21208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🂢 No If Yes, Give 14. Race - American Indian, 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **TEACHER EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **CHERTKOF** SIMONOFF SONIA ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA A. HOFFMAN / DAUGHTER 2905 W. STRATHMORE AVENUE - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or BETH TFILOH CEMETERY 10/05/2006 WOODLAWN, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Fun al Service Li 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRYHTHMIA 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter the derlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, for use es the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 4 Donknown 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a, Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03 D0064749 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 115 ROSELER ROAD - GLEN BURNIE, MD 21060 Rashid Ahmed Mohiuddin 3. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 6 2006 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland		artment of F		nd Mental Hy	giene Reg. No.	11115	31696
	Physici /Medic		1. Decedent's Name (First, Middle, La. James W. Maleo						2. Date of D Month Octob	Day	Y 200	3. Time of Death 12:10pм
	Examin		4a. Facility Name (If not institution, given 2014 Fleet Str				4b. City, Town, o			4c.	County of Dea	A
	Funeral Director		5. Social Security Number 214-12-2915 Usual Residence of Decedent	ex 7. Ag	e (In yrs. last	Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bi (Month, D) 8 - 23	irth ay, Year) -192		thplace (State or Foreign ountry) aryland
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Iteme 23e or 28e-f show aumatic event, Ira Medical Examinar must be redified at	Funeral Director	10a. State 10b. County Md. N/ 10e. Street and Number 2014 Fleet Str		10c. City, T	own or Loc		/.		10g. Citi	izen of What Co	-
9800	nours after death ural', or Iteme 23 Il Examinat mus	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 █ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	WWII	1	Vas Decedent of H i Yes, specify Cub	dispanic Originan, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)			erican Indian, ne, etc. ite
Baltimore, Maryland 21215-0036	e filed within 72 l Il Hygiene. other then "nat vent, tre Medic	Be Completed	15. Decedent's E. (Specify only highest grave Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last)	de completed) College (1-4or 5 N / A	i+)	(Give I life. [ent's Usual Occup kind of work done OO NOT use retire penter	during most o	f working Name (First, Middle	Но		orovement
Maryiar	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic eve	To	Joseph Malecki 19a. Informant's Name/Relationship (Diana Heinlein-	Type, Print)				and Number	nes Boro or Rural Route Numb asedena,	ber, City o	r Town, State,	Zip Code)
more,	0°= 5		20a. Method of Disposition 1 🎛 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)	Removal from State	20b. Place	e of Dispos etery, crem	sition (Name of natory or other pla	ce)	Date 0-9-2006	20c. Lo	ocation - City or	
Balt	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Licer			12	201 Dun	dalk A	Ave. Bal	timo		
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death)	one cause on each lin	10.		farction Disa	•	rdiac or respiratory a	arrest,		Approximate Interval Between Onset and Death
8/60,	sate be executed by sicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequen	ce of):	ny Disa	ease				10 years
O. Box 6	The law requires that the death certificate be executed that been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	ath 3 🗌	Ectopic pregnancy Other (specify)	/		2	23d. Date of de Month	livery Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions of Chrwic Obstvo		ut not resultin		derlying cause giv		İ	tobacco u Yes 2[o the cause of death?
Vital Records,		Completed	25 Was case referred to medical						1 ☐ Yes	opsy ormed? 2 No	prior to death?	utopsy findings available completion of cause of
ion of Vi	aing Phys .r After this funeral di	ation: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation			Outpatient b. Time of Injury	28c. Injur Wor	er: 4 □ Nursi	28d. Describe	idence (6	cify)
Division	To the Hospitel or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	i Certification;	3 Suicide 6 Could not be determined	building, etc	c. (Specify)				City or To	own, State)	ural Route Number,
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	Medical	(Check only one) 2 Medical Examone) 29b. Signature and title of certifier	ysician: To the best niner: On the basis of and manner sta	examination	and/or inv	estigation, in my d	pinion, death	occurred at the time	, date and 29d. Dat	te signed (Mont	h, Day, Year)
ŧ	n'y		30. Name and address of person who		eath (Item 23	la) (Type, F	Print) Catr	sooo ween	nagill	Oct	ober 5	, 2006
	Sta		4940 Easkrn 31. Date filed (Month, Day, Year)	32. Registra	Bal+i ar's Signature		, Maryli	and 21	1224			
	Registr	ar	000062	11116		· 1	100 A 8					

DHMH 17 Rev 1/2001

		•	For Amer State Amer	nd #17	State of M Per FH G	arylan 360 1	d / Dep 0/06/(artmer Hifica	nt of He te of E	ealth and I Death	Mental Hyg	iene	006	31	697
	Physici	an	Decedent's Name (First,) Frances E	lean	or O'l	earv			2. Date of Dear Month	Day	Year	3. Time	М
	/Medic		4a. Facility Name (If not ins			a.ı	0. O L	_	Town or	Location of Deat	Sept	ember 4c, Co	27, 2006 unity of Death	5:1	5 p. "
	Examin	er	-a. I domy Hamo (n not me		5400 Dunteacl	hin Dr		10.01.9	, , , , , , , , ,						
	Funeral		5. Social Security Number	6. Se			last birthday)		r 1 Year	If Under 24 Hrs.	Ilicott City 8. Date of Birth (Month, Day)			Oward lace (State	or Foreign
	Director		215-60-2895	10	□M 200 F		80 Yrs.	Months	Days	Hours Min.	(Month, Day	Year)	Coui	ntry)	
	ס		Usual Residence of Deced								Septembe	r 7, 19:		Michig	
	how		10a. State 10b. 0	County		10c. City	y, Town or Lo	ocation						0d. Inside	· .
	Ba-1-	cto	Maryland	Н	oward				E	Ilicott City				1 L Ye	s 2 No
	ih th	Sire	10e. Street and Number					10f. Zi	p Code		1	0g. Citizer	of What Cou	ntry?	
	ath w	ral	5400 Duntead	chin Dr.						21043			U.8		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural; or items 23a or 28a-f ehow other traumatic event, the Madical Exacilmer mark be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 Dr		12. Was Decedent Armed Forces? 1 Yes 2 14 If Yes, Give Year or Dates:	'		Was Dece If Yes, spe 1 ☐ Yes	- 1	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		Race - Americ Black, White, pecify:		
Ģ	2 ho	ted	15. De	ecedent's Edu	ucation		16a. Dece	dent's Usu	al Occupa	tion	4-1	16b. Kind	of Business/In		
218	within 7 ene. then "n	ple	(Specify only Elementary/Secondary (de completed) College (1-4or :	5+)	life.	DO NOT i	use retired)	uring most of wor	rking		Own	Home	
21	e filed within al Hygiene. I other then '	Ö	12						Họi	memaker			OWII	rionie	
	be file	Be (17. Father's Name (First, A		3.6					18. Mother's Nar	ne (First, Middle, i	Maiden Su	rmame)		
<u>la</u>	should but marked	10		Harry	Markin Mai	ctin					No	rah Br	oome		
Maryland	and and ls my		19a. Informant's Name/Re								ıral Route Number			Code)	
	1 and 2 Health em 27 i	1 3	Mr. Joseph H		y Soi	-				hin Dr. Ellic	ott City, Mary				
ore	iges 1 it of H if ite		20a. Method of Disposition 1 Burial 2 ☐ Crem		Removal from State	20b. P	lace of Dispo emetery, cre	osition (Na matory or	ime of other place	9)	Date	20c. Locai	tion - City or To	wn, State	
Ē	nit. Pages vartment of ortant: If it injury or o		4 ☐Donation 5 ☐ O				Good S	Shephe	rd Cem	etery 1	0/03/2006	E	Ilicott City	Maryla	end
Baltimore,	permit. Pages. Department of the timportant: If ite eny injury or of once.		21. Signature of Funeral S	11/1	1) 1200	in f			a	s of Facility uneral Hom	ne, P.A.	0			
			23a. Part1. Enter the dise	ase of comp	lications that cause	the death	n. Do not en	ter the mo	de of dying	g, such as cardia	or respiratory arr	est, N	7D 21043	Approxima	ate etween
	Physician		Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Apprehensions, or heart failure. History one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): The Consequence of the conditions of the condition of the conditions of the condition of the conditions of the condition of the												
	/Medical		resulting in death)		Due to (or as	a consequ	uence of):	/ /	910	` .				- 110	Year (
	Examiner		Sequentially list conditions		, Interi	Lh	al	100	9	DISEM	50		17	Two >	Enry
-	D =	ner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury		Due to (or as	a consequ			,						
(oute trans	Examiner	that initiated events c.												
Ö,	tificate be executed ig physicien and as the burial-transit	E	resulting in death) Last	- 1	Due to (or as	a consequ	uence of):						- 1		
68760,	cate b	edical		•	d	_		-					-		
Box 6	law requires that the death certifinas been signed by the attending I should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregn in the past 12 months 1 □ Yes 2 ☑ No 9 □ Unknown	ant	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	⊒Ectopic p ⊒ Other (s				230	d. Date of delive Month	ery Day	Year
P.O.	that the the the the the the the the the th	F.	Part II. Other significant of	onditions co	ntributing to death b	ut not resi	ulting in the t	underlying	cause give	n in Part I.	23e. Did tol	acco use	contribute to t	ne cause of	death?
ords	w requires been sign should be	sted by									1 🗆 Ye	s 2 🗆 N	No 3⊟Prot	ably 4	Unknown
Vital Records,	: The law cete has b page 2 s	Completed									24a. Was a autops perform	y	death?	psy finding mpletion of 2 No	s available cause of
Vit.	ician Sertifi ector	Be	25. Was case referred to r examiner?	-	Hospital:				Otho		ath (Check only on				
of	Phys this al dir	.T	1 ☐ Yes 2 ☑ No 27. Manner of Death		28a. Date of Inju		28b. Time of			4 Nursing F	fome 5 Reside			y)	
ב	or Attending Physician: ifter death. Director: After this certifica in by the funeral director,	lo	1 ☑Natural 5 ☐	Pending	(Month, Da	y Year)	Injury	M	28c. Injury Work	es 2 □ No	28d. Describe ho	ow injury o	ccanea		
isi	death death ctor: A	cat	2 ☐ Accident 3 ☐ Suicide 6 ☐	investigation Could not be	28e. Place of In	iury - At ho	me farm st				28f. Location (Si	reet and N	lumber or Bur	l Route Nu	mher
Division of	tal or Ars after al Direct	Certification:	4 - Homicide	determined	building, et	c. (Specify	y) 		ry, onice		City or Towi				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page	edical											tated. the cause	(s)	
	To the within 2 To the complet	Ĭ	29b. Signature and title of					29	c. License		1		igned (Month,		
)	:		Ihr	MD	PLD				ICE.	Spp9		7/2	28/0	6	
	1		30. Name and address of	person who c	completed cause of c	death (Item	23a) (Type	, Print)	n < H	rsnite.	1 Pm	1121	$\Delta L \Omega$		
	Sta Registr		31. Date filed (Month, Day	(Year)	32. Registr	ar's Signa	ture	100	الرحا	7-110		101	, , , ,		
	ricgisti	ज	0010	0 7000	182000	132	A A A B	3							

			For State Registrar	State of	of Maryland		artment of H		nd Ment		iene	06	31698	
			Decedent's Name (First, Mide	dle, Last)						ate of Deat	h		3. Time of Death	-
	Physicia		Bessie Naomi	Plaugher					1	fonth O	Day 03	Year 2006	10:35 AM	
	/Medic Examin		4a. Facility Name (If not instituti		ımber)		4b. City, Town, or	Location of I			7	unty of Death	110.00	_
			Manor Care -	Towson			Towson,	Maryl If Under 24	and		Ba	ltimor	<u> </u>	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 X F	7. Age (In yrs. last		If Under 1 Year Months Days		Min. (A	ate of Birth Month, Day,	Year)	9. Birthp Coul	place (State or Foreign ntry)	
	Director		212-34-6063 Usual Residence of Decedent		99	Yrs.			12	/25/19	906	Mar	yland	_
	land ow		10a. State 10b. Count	у	10c. City, T	own or Lo	cation					1	Od. Inside City Limits	_
	Mary fied	to	MD Bal	timore	Pho	enix							1 ☐ Ye <i>s</i> 2 No	
	r 284	irec	10e. Street and Number				10f. Zip Code			10	0g. Citizen	of What Cour	ntry?	_
	23a o	a D	3526 Sweet A	ir Road			21131				U.S.	Δ		
	ams r dea	Funeral Director	11. Marital Status		edent Ever in U.S. orces?	13.	Was Decedent of Hi f Yes, specify Cubar	spanic Origir n, Mexican, F	n? (Specify \ Puerto Ricar	Yes or No-	14.	Race - Americ Black, White,		
36	or it	by Fu	1 Never Married 2 Ma	rried 1 □ Yes If Yes, G	2⁄□ No ive			Specify:				ecity:		
21215-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or Itams 23a or 28a-f show event. If e M. diral Examin and Damiffied at	q pa	3 Widowed 4 Divorce	ont's Education		6a Dece	dent's Usual Occupa	ation			16h Kind o	Wh: of Business/In	ite	
15	in 72 n "na	Completed	(Specify only high	est grade completed)		(Giva	kind of work done d DO NOT use retired,	lurina most o	of working			, Daoi 1000 III	4400.7	
212	e filed within al Hygiene. I othar than ' vent, It e Ma	E	Elementary/Secondary (0-12) Unknown	College	1-40/37)	Con	fectioner				Candy	Making	g Industry	
	be filed tal Hygi d othar event.	Bec	17. Father's Name (First, Middle	e, Last)				18. Mother's	Name (Firs	st, Middle, N	faiden Sun	name)		
ylaı	should be nd Menta markad imatic ev	70	James Garfie	ld Neicewe	nder			Min	nie Ma	ay Eva	ans			
Maryland	2 short and ls m		19a, Informant's Name/Relation	iship (Type, Print)		19b. Mailir	ng Address (Street a	and Number	or Rural Rou	ite Number,	City or To	wn, State, Zip	Code)	
	is 1 and 2 should of Health and Men item 27 Is marks other traumatic		Karen J. Pres	ston (gran	ddaughter) 40	Bartley (Court	- Balt			ryland on - City or To		4
וסר	ages of the first or of or of		1 Burial 2 XCremation		State cem	etery, crei	natory or other place					•		
Baltimore,	iit. Pa intmer intent njury		' 4 ☐ Donation 5 ☐ Other		Metr		ematory,						Maryland Home, P.A.	
Ba	permit. Pages Department of h Important: If ite any injury or of		P A	Lacarda	1								nome, P.A. and 21087	•
			23a. Part1. Enter the disease,									Tall y In	Approximate	
	Priysician		shock, or heart failure. Li Immediate Cause (Final	st only one cause on		- 11	L E	7, 40					Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a Due to	(or as a consequen		eart Fa	11018					Years	
В	Examiner		Sequentially list conditions	b										
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		(or as a consequen	ice of):								
	and -trapet	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequen	on of):								_
8760,	cate be executed physician and the burial-trapett	ical E	3	Due to	(or as a consequen	00 01).								
687	ficate phys s the			d										
Box (leath certific attending pl	Ĭ,	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy		ne				23d.	Date of delive	ery	
Ď.	death e atte	icia	in the past 12 months?	4□Preg	birth 2 ☐ Fetal de nant at time of deat		Ectopic pregnancy Other (specify)					Month	Day Year	
P.O.	The law requires that the death certifica ate has been signed by the attending pt page 2 should be detached for use as It	Physician/Med	9 Unknown	9L]Unkr	nown									_
	es thi	by F	Part II. Other significant condi	tions contributing to d	death but not resultin	ng in the u	nderlying cause give	on in Part I.	2		-		ne cause of death?	
ord	v requir been si should	ted	COPIS							1 ∐ Ye	s 2 No	o 3 Prob	pably 4 Unknown	_
ec	e law l has b	Completed							2	24a. Was ar autops	V	prior to co	psy findings available mpletion of cause of	
E									1	perform ☐ Yes 2	DNo	death? 1 ☐ Yes	2 No	_
Vital Records,	Physician: Th r this certificate ral director, pag	Be c	25. Was case referred to medic examiner?	Hospital			othe Othe		f Death (Che					_
ō	Phys r this ral di	: To	1 Yes 2 No	1 . 1	Inpatient 2 ☐ ER of Injury 28 oth, Day Year) 28	Outpatier b. Time of	IL SELDON	4 Karvurs	_	5 ∐ Reside Describe ho		Other (Specificurred	ý)	-
on	Attanding Phy r death. actor: After thi by the funeral of	tlor	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ling (Moi tigation	nth, Day Year)	Injury		(? Yes 2⊟No)					
Division of	l or Attano after death Diractor: I in by the	ifica	3 ☐ Suicide 6 ☐ Coul	mined 200, Plac	e of Injury - At home ling, etc. (Specify)	, farm, str	eet, factory, office			ocation (Str		umber or Rura	A Route Number,	
ā	tal or s afte at Dir ed in	Certification:	4 E Homedo	Duic	illig, etc. (Specify))		ny or rown	, Olato)			
	To the Hospital or At within 24 hours after or To tha Funeral Dirac completely filled in by	dical		ing Physician: To the I										
	the hin 24 tha F	Medi	one) 29b. Signature and title of certif	and mai	nner stated.		29c. License					gned (Month,		_
	To Cor	-	pron 18		\cap			61/9	S	1	-	4,200		
	1					a) (Tuna		0 77 /	1					
	ン		30. Name and address of person Jason Black	MIN Completed Call	565 Not	- A C	harbs 57.	Suite	209.	Town	De IL	11/21	204/	
	Sta	te	31. Date filed (Month, Day, Yea		Registrar's Signature					, 000		<u> </u>		_
	Registi		007.0	2006	Ro	A STATE OF THE PARTY OF THE PAR	- PP 0							
DH	MH 17 Rev 1/2	001		, 2000	Mary No	A. S. S. S. S. S. S. S. S. S. S. S. S. S.	DOST D							
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		1 - For Stete Registrar	State of Marylan	id / Depa <i>Cer</i>	ırtmer <i>tificat</i>	nt of He <i>te of D</i>	ealth and l eath	Mental Hy	/giene Reg. No.	006	31699
		Decedent's Name (First, Middle, Last)						2. Date of De	eath		3. Time of Death
Physic		William O.	Po	rter				Sept.	17. 2	Year	10:55a [™]
/Medi Exami		4a. Facility Name (If not institution, give st			4b. City	Town, or L	ocation of Death			County of Deat	
		Citizens Nursing	Home		Fı	ederi	ck			Freder	ick
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Unde Months		If Under 24 Hrs. Hours Min.	8. Date of Bi	rth av. Year)	9. Birtl	nplace (State or Foreign untry)
Director		216-01-2821	^{M 2□ F} 91	Yrs.	141011(113	Days	110010	Nov. 3			ryland
pu *		Usual Residence of Decedent 10a, State 10b, County	10c Cit	v. Town or Lo	ration						10d. Inside City Limits
aryta •ho	7	Maryland N/A	[altimo							1 ☐Yes 2 ☐ No
he N	Director	10e. Street and Number				o Code			10a Citia	en of What Co	
with					101. 24		000				ondy.
deeth with the Maryland oma 23a or 28a-f ehow ir must be notified at	Funeral	2122 Ramsay St.	2. Was Decedent Ever in U	.S. 13. V	Vas Dece		.223 panic Origin? (Si	pecify Yes or N	USA 0- 1	4. Race - Ame	rican Indian,
ter d	Fun	1 Never Married 2 Married	Armed Forces?	H	Yes, spe	cify Cuban,	panic Origin? (Si Mexican, Puert	o Rican, etc.)		Black, White	e, etc.
urs a	ğ	3 Widowed 4 □ Divorced	1 🙀 Yes 2 🖸 No If Yes, Give WW Year or Dates:	II 1	☐ Yes	av⊡ No	Specify:			Specify:	White
thin 72 hours affer "natural", or Medical Exam	Completed	15. Decedent's Education (Specify only highest grade	ation	16a. Deced	ent's Usu	al Occupati	on ring most of wor	kina	16b. Kin	d of Business/	Industry
thin 7	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	O NOT	ise retired)	ing most of wor	<i></i> ,,,,,			
A gien	S	12		La	abore					ctory	
Mental Hy Mental Hy arked oth	Be	17. Father's Name (First, Middle, Last)				1	8. Mother's Nan	ne (First, Middle	, Maiden S	Sumame)	
Menid h	ုင္	William	Porter				Hana			erger	
142 Shigh and 157 is m	1	19a. Informant's Name/Relationship (Typ			•		d Number or Ru				(ip Code)
E B B B		Carolyn True (Guard	·			•	., Fred	Date			T Ci-1-
or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State Ba1	Place of Disposemetery, crent timore Loudor	natory or	other place) 12 torv			20¢, Lo	ation - City or	Town, State
permit. Pages 1 au Department of Hea Important; if item any injury or other once.		4 □ Donation 5 □ Other (Specify)									Maryland
Dal Bermil Depar Mpor Iny ir	1	21. Signature of Funeral Sawing Confee					of Facility L				
4 4 5 4 4		23a. Part. Eater the disease, or complic	ations that sound the deat				s Ave.,			FID 2122	Approximate
	B	meck, or heart failure. List only one									Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	Cange	istive	14	eant	- +24	unc			weeks
/Medical Examiner			Due to (or as a consect	uence of):	,	11.0	•				10000
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	quence of):	וואמ	W-JU	n				week
rted nsit	듵	cause. Enter Underlying Cause (Disease or injury		,							
exect n and al-tra	Examin	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):							
cate be executed physicien and it the burial-transit	dlcal	d.									
	Ψ			-							
death certifications of for use as	clan/M	23b. Was decedent pregnant	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopics	regnancy			2	3d. Date of del	
death death	100 M	in the past 12 months? 1 🗆 Yes 2 🗋 No	4☐Pregnant at time of o		Other (s					Month	Day Year
by the	Physi	9 ☐ Unknown									
The law requires that the de tie has been signed by the page 2 should be detached	b y	Part II. Other significent conditions cont	ributing to death but not res	ulting in the ur	nderlying	cause given	in Part I.				the cause of death?
e duit	ted							1	Yes 🗶	No 3∏Pr	obably 4 ☐Unknown
6 V C	ple							24a. Wa:	psy	prior to d	topsy findings available completion of cause of
- (0	Completed							pert 1 ☐ Yes	ormed? 2 No	death? 1 ☐ Yes	2□ No
OI VILLII Physician: T r this certificat rral director, pa	Be	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only	опе)		
Physi rthis o	2	10 192 97 140		ER/Outpatien			4 Nursing H	ome 5 Res			cify)
- 2 2 2 2	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury a Work?		28d. Describe	now injury	occurred	
tor:	Icat	2 Accident investigation 3 Suicide 6 Could not be	On Dian of Injury At h	omo form etc	M (set		es 2 No	29f Location	(Street and	Number or P	iral Paula Number
LIVISION I or Attending after death. I Director: Afte	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specia	(y)	et, Iacioi	y, once			wn, State)		iral Route Number,
To the Hospital or Al within 24 hours after or To the Funeral Direc completely filled in by		29a. Certifier Y Certifying Physi	cian: To the best of my kno	owledge death	OCCURRE	t at the time	date and place	and due to the	cause(s)	and manner as	stated.
24 h	Medical	(Check only 2 Medical Examinone)	er: On the basis of examination manner stated.	ation and/or inv	estigation	n, in my opi	nion, death occu	rred at the time	, date and	place, and due	to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier			29	c. License				signed (Monti	
F > F 0		\	>			Dy	13091		9	-18-0	6
\wedge		30. Name and address of person who con	npleted cause of death (Iter	n 23a) (Type,	Print)					0	
2		Saced Za	idi MA	8	01	JOLI	L Hou	se A	ve,	fred	benck MN
St	ate	31. Date filed (Month, Day, Year) 200	32 Registrar's Signa	ature	calle)	¢			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31700 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Herbert Franklin Parmenter <u>11:</u>12A [™] October 4, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Collingswood Nursing Home Montgomery If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1**X**M 2□F Months 018-07-5694 90 1916 Massachusetts Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28e-f ehow 1 X Yes 2 No Directo Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 20850 United States 299 Hurley Avenue Pages 1 and 2 should be filed within 72 hours after death ment of Heatth and Mental Hygiene. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Mar Efementary/Secondary (0-12) College (1-4or 5+) Private Home 12 Groundskeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bessie Hammond 2 Theodore Parmenter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3302 Winnett Road, Chevy Chase, Maryland 20815 Sandra E. McManaway / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If its any injury or ot once. October 6, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funerah Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. lette Dans Un M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition Physician Emphysema resulting in death) /Medical Due to (or as a consequence of): Examiner Advanced Alzheimer's Type Dementia Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine sicien and burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of defivery 1 Live birth 2 ☐ Fetaf death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No should 24a. Was an autopsy performed? 1 ☐ Yes 2 🖾 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hes page 2 this certificate director. Be 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٦ 1 Yes 2 No 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel 🛣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year) 000 0 2006 State Registrar

29b. Signature and title of certifier



MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

29c. License number

23365

29d. Date signed (Month, Day, Year)

October 5, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Of John Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Rita Renauer September 18, 2006 4:39 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville
If Under 1 Year | If Under 24 Hrs. | Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🔀 F Months Days Hours Yrs. Director 579**-**38-0795 May 19. 1930 Washington, D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location id 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
27 is marked other than "natural", or Items 23s or 28e-1 ehow traumetic event, the Medical Examiner must be notilized at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Marvland | Montgomery Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6610 Greyswood Road 20817 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√ No Specify: ð Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Resource Center Representative Medical Association 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Kennedv Madeline Harper 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , 1 and 2 st of Health ar litem 27 tr Edward J. Renauer, Sr./Husband 6610 Greyswood Road, Bethesda, Maryland 20817 Baltimore, 20b. Place of Disposition (Name of Date 20a, Method of Disposition 20c. Location - City or Town, State Pages 1 Gate of Heaven permit. Pages
Department of
Importent: If it
eny injury or o t Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 22, 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland Cemetery
22 Name and Address of Facility Robert A. Pumphrey Funeral Home Chase, Inc.

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest,

Approximate

Approximate 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure /Medical KATION APP OUTED BY NEOKAL TAMMER Due to (or as a consequence of) Examiner Quadriplezia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine ed by the attending physicien and detached for use as the burial-transi Pacticonfa resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Concestive Heart Failur IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4□ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown that the sate has been signed by I page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Records, Spinal Cord Injury 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Pleural Effusion 24a. Was an autopsy performed? Atrial Fibrillation 1 ☐ Yes 2 ☐ No 1 Yes 2√ No Vital After this certification Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 XYes 2 Ne Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ð 27. Manner of Death 28b. Time of 28c. Injury at Work? Subject sustained a neck 28a. Date of Injury (Month, Day Year) Certification: Division + Natural
2 XAccident 5 Pending after death. investigation 1 Yes 2 No 11/20/2005 Unknown^M injury on a sliding board the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide in by t 28f. Location (Street and Number or Rural Route Number, To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 7300 MacArthur Boulevard Children's Museum 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D55054 18/2006

State

Registrar

32. Registrar's Signature

17519 Redland Road, Rockville, Maryland 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

miles of

Attan Kasid, M.D.

			1 - State Registrer	State of Mary		artment rtificate			=	gien,	7 1 1) 6	31702
	Dhuniai		Decedent's Name (First, Middle, Last)						2. Date of De			Year	3. Time of Death
	Physici /Medic		NANCY LEE MAR	RIE NOLTE	RITTER				OCTOR	BER	4,	2006	3:00 FM
	Examin	er	4a. Facility Name (If not institution, give stress of Saint Joseph N	ledical C					vson		c. County	of Death Balt	imore
	Funeral Director		5. Social Security Number 218-28-1529 Usual Residence of Decedent	7. Age (In	yrs. last birthday) 73 Yrs.	Months	Days Days	Hours M		th ay, Year 193	32	Coun	lace (State or Foreign try) yland
	/land		10a. State 10b. County	10	c. City, Town or Lo	cation						10	0d. Inside City Limits
	a-f sh	tor	Maryland Baltimore	County	Timo	onium							1 ☐ Yes 2 🙀 No
	or 28	Director	10e. Street and Number			10f. Zip	Code			10g. C	itizen of	What Coun	try?
	s 23e		12350 Rosslare Ri	dge Road, Was Decedent Ever		144= D===d		093	/0 N N			USA	and the state of
' O	r item	Funerai	11. Marital Status 12 1 □ Never Married 2 ☒ Married	Armed Forces?				, Mexican, Pu	(Specify Yes or No erto Rican, etc.))-		ce - Americ ck, White, e	
9	rai', o	by	3 Widowed 4 Divorced	1 ☐ Yes 2 TNo If Yes, Give X Year or Dates:		1∐Yes 2	₹ No	Specify:			Specif	v: Whi	te
2-0	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28a-f show the Medical Examinat must be notified at	Completed	15. Decedent's Educa (Specify only highest grade of		(Give	dent's Usua kind of wor	k done du	ion iring most of v	vorking	16b. i	Kind of B	usiness/Ind	lustry
121	within ene. than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>oo not u</i> s emaker	,				O	D i -l	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-1 show any injury or other treumatic event, the Madical Examinat must be notified at once.	Be Co	17. Father's Name (First, Middle, Last)		HOME	maker		18. Mother's N	lame (First, Middle			Resid	ence
/lar	Menta Menta arked	To B	John P. Nolte					Ma	rie		H	urley	
Jan	l 2 sho n and remy	13	19a. Informant's Name/Relationship (Type	,	1				Rural Route Numb				21093
	1 and Heatth em 27 ther t		Robert W. Ritter (20a. Method of Disposition	Husband)	Ob. Place of Dispo	sition (Nam	na of		Road, #	302 20c I	Tí	City or To	m, Marylark
JOE L	ages ant of nt: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	cemetery, crer Green Mou	natory or ot	ther place,	1	16 12006			ŕ	Maryland
Baltimore,	mit. F partme sortar f injur		21. Signardin of Foreral service Licensee		22	Name and	d Address	ol Facility	ld Funera	Jua.	1 L 1 lil	ore,	Maryrand
<u>~</u>	Depa Impo eny ir	l III	Martin D Marras	n	N 6	11 tcne 5500 y	ork Zork	ledele Road	ld Funera Baltimore	II H	ome,	inc.	1.21.2
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the cause on each line.	death. Do not ent	er the mode	e ol dying,	such as card	iac or respiratory a	rrest,	aryı	and 2	Interval Between
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В		by Physician/Me	in the past 12 months? 1 □ Yes 2 No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		Ectopic pre Other (spe					Mo	nth	Day Year
P.O.	hat the	Phy	9 ☐ Unknown N Part II. Other significant conditions contri	buting to death but no	ot resulting in the u	nderlying ca	uica awan	in Part I	23a Did t	obacco	use conf	ribute to th	e cause of death?
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/ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?	1			V -		eath Check only o	-1		j j	
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	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page												
	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examine	ian: To the best of mo On the basis of exa and manner stated.	y knowledge, death mination and/or in	n occurred a vestigation,	at the time in my opir	, date and pla nion, death oc	ce, and due to the curred at the time,	cause(s date an	and ma d place,	inner as sta and due to	ated. the cause(s)
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DHMH 17 Rev 1/2001

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	/Medic Examin		GERTRUDE CRAIT 4a. Facility Name (If not institution, give s			4b. Cit	y, Town, or Lo	ocation of De			County of Dea	1.000	ţ
			Roland Park Place					Ltimore			N/A		
	Funeral Director		242-74-2020	7. Age (In yrs. 95	last birthday) Yrs.	If Und Month		f Under 24 H Hours Mi		$^{\text{th}}_{ay, Y \theta ar)}$	9. Bir 1911 M	thplace <i>(State or Fore</i> bu <i>ntry)</i> aryland	eign
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation						10d. Inside City Lin	nits
	Mary	tor	Maryland N/A		Baltimo	ore						1 X Yes 2 □	No
	or 284	Directo	10e. Street and Number				Zip Code			10g. Cit	tizen of What Co	ountry?	
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<u>la</u> n	uld be Mental irked o	To Be	William Pinkney	Craig				Julia	Ras	sin			
-	2 6 6		19a. Informant's Name/Relationship (Typ			•			Rural Route Numb			Zip Code)	
	1 and Health em 27 ther tr		Sally K. Craig 20a. Method of Disposition	(niece)	Place of Dispo	sition /A	ame of	oad Ba	altimore,		yland ocation - City or	21286 Town State	
בֿ ב			1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crer uid Ric	-		rv 10	-9-06			, Maryland	1
Baltimore,	permit. Page Depertment of Important: If any Injury or ance.		21. Signature of Funeral Service License	е		_		-	ld Funera Baltimon				L
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	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.	DEM	ent	la					Interval Between Onset and Death	
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68760,	ficate t physic s the b	edicai	d										
Box	eath certiff attending I for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths?	3c. If yes, outcome of pregn.	el death 3		pregnancy				23d. Date of de Month	livery Day Year	
P.O.	the de by the a	nysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of o	Jean 5	Other (specify)						
ds, P	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit		Part II. Other significant conditions con		sulting in the u	nderlying	cause given	in Part I.		tobacco Yes 2		the cause of death?	
Vital Records,	s beer	Completed							24a. Was		24b. Were a	utopsy findings availa	able
		mo					-		auto perf	ormed? 2 No	death?	completion of cause 2 □ No	of
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0	nding lath.	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	М	28c. Injury a Work? 1 ☐ Ye	s 2 No		,	,		
Division of	To the Hospital or Attending Physician: within 24 hours slier death of the Funerel Director: After this certifical completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, fact	ory, office		28f. Location City or To			ural Route Number,	
	Hospil 24 hour Funer tely fills	Medical (29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kno	owledge, death ation and/or in	occurre vestigation	ed at the time, on, in my opin	date and pla	ace, and due to the courred at the time,	cause(s date and) and manner as d place, and due	s stated. to the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		2	9c. License n	umber		29d. Da	ite signed (Mont	h, Day, Year)	
)	rs r o		> Mercing 3	nmo			03	102		00	ohev 5	, 2006	
	(a		30. Name and address of person who con	mpleted cause of death (Iter	п 23а) (Туре,	Print)	-1		7 1	B.	no no		
	V Sto		31. Date filed (Month, Day, Year)	32 Registrar's Sign	th ct	AY	15 >1	THEY	BALL	IM	ore m	TYTIANO	
	Sta Registr		OCT 0 6 20	32. Registrar's Sign	pr M	The state of the s			(-	

/B B	ian	1. Decede	ont's Nam	e (First, Middle, La	si) am Thoc	1 4	3c			i	Date of Dea Month IC+db	Day	Year POOCO	3. Time of [
/Medi Exami		4a. Facility	Name (e street and number		<i>)</i> 1.	4b. City, Town, o	or Location of D		CTCIO	7	nty of Death	
Funeval		5. Social S	CUC	Mar Jumber 6. S	Sex 7. A	ge (In vrs	last birthday)	If Under 1 Year	Onium If Under 24		Date of Birtl	B	altin	none
Funeral Director		220-	26		M 2□F	77	7 Yrs.	Months Days		lin.	Month, Day	y, Year)	9. Birth Cot	place (State or Intry)
ahow		10a. State		10b. County		10c. Ci	ty, Town or Loc	ation						10d. Inside City
rme 23a or 28a-f ahov Irmust be notified at	ector	mi)				Balti	more						1 Yes
3a or 2 at be n	Funeral Director	10e. Stree	and Nu	mber	1400.10			10f. Zip Code	INIK			10g. Citizen o	of What Cou	intry?
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9 3	by Fu			ied 2 Married 4 Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	No		☐ Yes 2 No	Specify:		,,, 0.0.,	Spec		, 910.
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pariment of sortant: If It / Injury or c				☐ Cremation 3 ☐ 5 ☐ Other (Specify	Removal from State y)	10-	uid Pri	dge com	stary 10	1910	6	Pik	25411	P.MI
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DHMH 17 Rev 1/2001

OCTOBER 4, 2006

GEORGE REED

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Las 2. Date of Death Day Vear **Physician** 1:30 AM October 04 2006 erome /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give Examiner TIMORE Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Yea)2-22-1 5. Social Security Number **Funeral** Days 3662 Months Hours Min M 2□F 215-40-Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. toside City Limits 10a State traumatic event, the Medical Examinar must be notified at 1 Yes 2 Yo Director 28a-1 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Items 23a Completed by Funeral death Was Decedent Ever in U.S. Armed Forces?

1 Yes No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 "natural", or Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. ecodary (0-12) College (1-4or 5+) Driver ranspor 18. Mother's Name (Mst. Middle. Be and Mental ! c)0h ဨ Kana Health Item 27 i 20a. Method of Disposition 20c Location Depertment of H important: If Ite eny injury or ot once. 1 Burial 2 Cremation 3 R
4 Docation 5 Other (Specify)
Signature of Fur by it Service Licens 3 Removal from State 1133 Approximate Intervat Between Onset and Death 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. tmmediate Cause (Finat Physician Sepsis week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 3 day Preumoni Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the deat certificate be executed Com cor 3 days man Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sete has been signe page 2 should be rens 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificete After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitat: 1 X Inpatient Other: Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No I Director: A d in by the fi within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tniury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063176 Alter Iwa america e M.D. October 04,2006 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 6 2006

wallingues

32. Registrar's Signature

Memorial HospitalMID

			For State Registrar		of Marylar	nd / Depa <i>Ce</i>	artment of I- rtificate of I	lealth a <i>Death</i>		Reg. No		
	Physici	an	Decedent's Name (First, Middle,	Last)					N.	ate of Death Month Da		3. Time of Death
-	/Medic	ai	Mildred 4a. Facility Name (If not institution,	nive street and r	number)	Ri	charts 4b. City, Town, o	r Location of	f Death		5 200 County of Dea	6 111:3/
	Examin	er	6665 Oak Ridge	_	umbery		Hebron	Location			comico	
d) ek	Funeral	À		6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. D	ate of Birth Month, Day, Year	Q Rie	thplace (State or Foreign ountry)
1	Director		219-16-7682	1 □ M 2 🛣 F	84	Yrs.	Wortins Days	Hours	3/:	19/1922	Mar	yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	Mary -f ah	tor	Maryland Wicomi	20	н	ebron						1 ☐ Yes 2 🙀 No
	h the	irec	10e. Street and Number			DION	10f. Zip Code			10g. C	tizen of What C	ountry?
	23e c	Funeral Director	6665 Oak Ridge	Drive			21830				JSA	
	ar dez	une	11. Marital Status	Armed	cedent Ever in U Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Orig an, Mexican,	in? (Specify , Puerto Ricar	Yes or No- n, etc.)	14. Race - Am Black, Whi	
36	rs afte	by F	1 ☐ Never Married 21 Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, (Year or	s 2⊠No Give Dates:		1 ☐ Yes 2 ☑ No	Specify:			Specify:	White
Ö	2 hou atura	ted	15. Decedent	s Education		16a. Dece	dent's Usual Occup	ation		16b. I	(ind of Business	/Industry
215	thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	kind of work done of DO NOT use retired	d) most	or working			
2	ygien ygien her th	Con	12			Ног	nemaker	40 14-15-	4- N (5":-		vn Home	
Maryland 21215-0036	ntal Hed ot	Be	17. Father's Name (First, Middle, L Harry E		ardesty				adie	st, Middle, Maidei Wil:		Ogden
2	should nd Me mark matic	ဥ	19a. Informant's Name/Relationsh		aracscy	19b. Maili	ng Address (Street					
Z	is 1 and 2 so if Health ar item 27 is other treu		John W. Richarts		on)	155595555	PENCHE IN THE			555000000		
Jre,	ss 1 a		20a. Method of Disposition		20b.	Place of Dispe	Oak Ridge osition (Name of matory or other place	ce)	Date	20c. L	ocation - City o	Town, State
Ē	Page ment c		t y D Burial 2 □ Cremation 4 □ Donation 5 □ Other <i>(Sp</i>		Lo		ark Cemet					Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural, or items 23e or 28e-f show supprinciply or other treumatic avant, the Medical Examinar must be notified at angle.		21. Signature of Funeral Service	icetti ee			2. Name and Addre					
_	40 E E O		1				3620 Wilk				, MD 212	
		4	23a Shock, or heart failure. List of Immediate Cause (Final	omplications that only one cause or i \	t caused the dea n each line.	ith. Do not en	ter the mode of dyin	ng, such as c	cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical	2	disease or condition resulting in death)	a. The	olor as a conse	(to concup	4-16	-				
	Examiner			C	office as a conso		raced	F				
ļ.	71 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	O. Due t	o (or as a conse							
/	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.	- (
8760,	cate be executed oblysician and the burial-transit	al E		Due	o (or as a conse	quence or):						
687	tificate ng phys as the	Physician/Medical		d.								
Вох	eath certifica attending ploor for use as t	M/U	IF FEMALE: 23b. Was decedent pregnant		outcome of pregr		7				23d. Date of de	blivery
	O O	sicia	in the past 12 months?		birth 2 Fet gnant at time of		⊒Ectopic pregnancy ⊒ Other (specify)	<i>'</i>			Month	Day Year
P.O.	that the ed by th detache	Phy	9 Unknown							OC. Bidata		o the cause of death?
	ires tha signed d be det	þ	Part II. Other significant condition	is contributing to	the string of the	suiting in the L	inderlying cause giv	en in Part I.			k .	robably 4 Unknown
Ö	law requires as been sign 2 should be	etec	13/201/12/10	7	1100117)				24a. Was an	_	
Vital Records,	The lavate has	Completed	Topicos 10	\						autopsy performed?	prior to death?	utopsy findings available completion of cause of
tal	ician: Th certificate rector, pag	ø	25. Was case referred to medical	15				26 Place		eck only one)	1 □ Ye	s 2No
	S S	To B	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	BR/Outpatie	nt 3 DOA Oth	05		5 Residence	6 ☐Other (Spe	ecify)
n of	ng Phys ter this neral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Dai	e of Injury onth, Day Year)	28b. Time o	of 28c. Injur Wor			Describe how inju		
Sio	Attending in death.	catle	2 Accident investig	ation				Yes 2□N				
Division	or Att	Certification:	4 Homicide determine	289. Pla	ce of Injury - At I Iding, etc. (Spec	nome, farm, st ify)	reet, factory, office			ocation (Street a City or Town, Stai		Rural Route Number,
_	Hospital 94 hours a Funerel I tely filled		29a. Certifier 152 Certifying	Physician: To t	he best of my kn	owledge, deal	th occurred at the tir	ne date and	d place, and o	lue to the cause(s	and manner a	s stated.
	To the Hospital or Attanding Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical		xaminer: On the			vestigation, in my o					
	To the within 2 To the complet	Me	29b. Signature and title of/certifier				29c. Licens	e number		29d. D	ate signed (Man	th, Day, Year)
			Jumo	Y			3	825	7	9	25/0	(
	H		30. Name and address of person v	who completed ca	use of death (Ite	m 23a) (Type	Print)	, (1 1	1150	00	Con City
32	' \		31. Date filed (Month, Day, Year)	CK .	Registrar's Sign	nature	1311	1	CC 3 F	or Ha	7,0	1771845
	Sta Registi		OCT 0 6 2	1 60	270 A	y fa	MES					

_		,	For State Registrar		aryland / Dep		f Health a		Reg. No.	6 31707
	Physici /Medic Examin	al	4a. Facility Name (If not institution, giv	SEMAN e street and number)	4 -		m, or Location of		Day	
	Funeral Director		200 17 2310		ge (<i>In yr</i> s. <i>last birthda</i>) 80 Yrs.				irth	9. Birthplace (State or Foreign Country) CUBA
	the Maryland 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD N/A		10c. City, Town or t	TIMORE				10d. Inside City Limits 1 X Yes 2 □ No
	ath with t	rai Dir	3807 LABYRINTH			10f. Zip Coo		21215	10g. Citizen of Wh	USA
9800	ours after der ral', or Items Examinario	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13	Was Decedent If Yes, specify (1 ☐ Yes 2 🔏		in? (Specify Yes or N Puerto Rican, etc.)	14. Race Black Specify:	- American Indian, White, etc. WHITE
21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or Items 23e or 28e-f show unatic event, the Modical Exemitive could be incitified at	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12) 12	ducation ide completed) College (1-4or	(Giv	edent's Usual Oc e kind of work do DO NOT use re JSEWIFE	one during most	of working	16b. Kind of Bus	,
Maryland	d 2 should be file th and Mental Hyo 7 ie marked othe traumatic event,	To Be (17. Father's Name (First, Middle, Last, JACOB		CHIRINS	SKY		's Name <i>(First, Middl</i> ID A	e, Maiden Sumame,	FINE
45	and 2 ealth a m 27 is		19a. Informant's Name/Relationship (GRACE WEISSMANN 20a. Method of Disposition	/ DAUGHTE	R 380	O7 LABYR	RINTH RO	Or Rural Route Num. AD - BALT] Date	MORE, MD	
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny injury or ott		1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 2) 21. Signature of Funeral Service Licer	y)	SHAAREI	ZION CEM 22. Name and Ac	TETERY 1		NSON & BF	DALE, MD ROS., INC. LE, MD 21208
8760, E.	Physician hysician and hysician and hysician and phuai-transit the primaritransit the primary from the phuai-transit the primary from the phuai-transit the	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of): a consequence of):	4	oyilig, such as c	ardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
P.O. Box 68	Attending Physicien: The law requires that the death certifica croads. ardeath. croads. the this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the funeral director.	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	□Ectopic pregna □ Other (specify			23d. Date Monti	
	uires that signed by id be deta	d by Pr	Part II. Other significant conditions of	contributing to death b			given in Part I.			ute to the cause of death?
Division of Vital Records,	The law requireate has been spage 2 should	Complete						24a. Waa auto peri 1 🗆 Yes	opsy pri ormed? de	ere autopsy findings available or to completion of cause of ath? Yes 25 No
of Vita	ding Physicien: Th. After this certificate funeral director, pag	To Be	25. Was case referred to medicat examiner? 1 ☐ Yes 2 No	Hospital:		III 3 DOX	Other: 4 Nur:	of Death <i>(Check only</i> sing Home 5 - Res		(Specify)
sion o	Attending P death. ctor: After to y the funera	Certification:	27. Manner of Death 1 Shatural 5 Pending 2 Accident investigation		y Year) 28b. Time Injury		njury at Work? 1 □ Yes 2 □ N		how injury occurred	1
Divis	To the Hospital or Attan within 24 hours effer deatl To the Funeral Director: completely filled in by the		3 Suicide 6 Could not b 4 Homicide determined	building, et	ury - At home, farm, s c. (Specify)			City or To	own, State)	or Rural Route Number,
	To the Hosp within 24 hou To the Fune completely fil	Medicai	(Check only 2 Medical Exar	ysician: To the best niner: On the basis o and manner st	of my knowledge, dea f examination and/or i ated.	nvestigation, in n	ny opinion, death	place, and due to the occurred at the time	, date and place, an	d due to the cause(s)
		2	29b. Signature and title of certifier		ta m.o	01	ense number		29d. Date signed (ひむかい	
	3		30. Name and address of person who 31. Date filed (Month, Day, Year)	HOSPITAL	CENT		RANK	P MEHY		0 21133.
	Sta Registr		CCT 0 6 20		ar's Signature	3306				

			1 – For State Registrar	State of Maryla			of He	ealth and	d Menta		200	6_31708
ı	Physici		1. Decedent's Name (First, Middle, Last	ROBB	1.436				Mor	1. 1 .	Day Yes	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, 7	Town, or l	ocation of De		ia	4c. County of D	Howard
	Funeral Director		5. Social Security Number 6. Se 227-22-3220 10 Usual Residence of Decedent	7. Age (In yrs.	91 Yrs.	If Under Months	1 Year Days	If Under 24 H Hours M	lin. (Moi	of Birth oth, Day, Ye lay 12, 1		Birthplace (State or Foreign Country) Virginia
	e Maryland a-f ahow	ctor	10a. State 10b. County	oward	ity, Town or Lo	ocation	E	llicott City	y			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 26	I Dire	10e. Street and Number 2774 St. John's Lane			10f. Zip	Code	2104	4 2	10g.	Citizen of What	Country? U.S.A.
900	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or Items 23a or 28a-f ahow event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedif Yes, spec		panic Origin? , Mexican, Pu Specify:	(Specify Yes jerto Rican, e	or No-	14. Race - A Black, W Specify:	merican Indian, thite, etc. White
Maryland 21215-0036	d within 72 ho giene. Ir than "natu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual kind of won DO NOT us	k done du e retired)	ion ring most of memakei	•	16b	. Kind of Busine	ss/Industry Dwn Home
yland;		To Be C	<u> </u>	p Delp						Har	den Sumame) nna Goins	
re, Mar	1 and 2 Health a em 27 Is ther tra		19a. Informant's Name/Relationship (T) Mr. G. Randall Robbi 20a. Method of Disposition	ns Son	19b. Mailir	2774 Station (Nam	t. John e of	's Lane E		y, Maryl	ty or Town, State and 21042 Location - City	
Baltimore,	permit. Pages Department of I Important: If Its any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligens	ternoval from State	Good	Shepher	d Cen	netery of Facility	10/06/2 lome, P.A		Ellicott	City, Maryland
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	w requires that the de been signed by the a should be detached f	by	Part II. Other significent conditions con	ntributing to death but not res	sulting in the ur	nderlying ca	use given	in Part I.	238	. Did tobacc		to the cause of death? Probably 4 Dinknown
al Records,	: The law re cate has be ; page 2 sho	Completed								Was an autopsy performed Yes 2	? prior t	autopsy findings available o completion of cause of es 2 100
ξ.	sician s certifi irector	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatien	t 3 🗆 DOA	Other		Death Check	ROST 100	A 77011 40	
Division of Vital	To the Mospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		27. Manner of Death 1	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury		c. Injury a Work?	4 🗀 Nursing			6 □Other (S) ijury occurred	oecity)
Divis	vital or Atternation after de rai Diracto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	(y)				City	or Town, St	ate)	Rural Route Number,
	s Hosp 24 hou s Fune letely fi	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exami	sicien: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred a restigation, i	t the time in my opir	, date and pla nion, death oc	ce, and due to courred at the	o the cause time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)
	within To th Comp	Me	29b. Signature and title of certifier	lly dis		29c.	License 1	number 8	7		Date signed (Mo	nth, Dey, Year) 3, 2006
	M		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type, I	Print)	R	INF	THE	JET	2 Or	1201.
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 6 200	32 Registrar's Signa	erute	dis		•		A		

Sullivan, Catherine 219-01-2369.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 🔑 🛭 🕦 💍 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2006 /Medical 4a. Facility Name (If not institution, give street and/mymber) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hactord If Under 24 Hrs. Min. Social Security Number 19-01-336 6. Sex Tast birthday If Under 1 Year Birthplace (State or Foreign Country) Days 1□M 20 F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the McCical Examinar houst be multiled at 1 Yes 2 No Directo 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 6 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Neyer Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Whit ģ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) at Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth enty injury or other treumatic event QDGS. 1 a. Informant's Name/Pelationship (Type, Print) 19b. Mailing Ad ress (Street and Number or Rural Route Number, City or Town, Stat., Zip Code) 20b. Place of Disposition (Name of cometery, cromatory or other place) 20c. Location - City 20a. Method of Disposition Date 3 Removal from State 1 Burial 2 Cremation 4 ☐ Doration / 5 ☐ Other (Specify) 21. Signature / Funeral Service / Insee 22. None and Address Pufacilly ral and cremation Sarvice rd. Parkville, mo 21234 Approximate Interval Between Of set, and Death 216 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LIUMUNIG /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No Denintio 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 25 No 1 Yes 2□ No 1 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 1. CNatural 2 Accident Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Scott

31. Date filed (Month, Day, Year)

tasw111

6 2006

Avenue

North

d

32 Registrar's Signature

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 5 2006

32. Registrar's Signature

		For State Registrar	State of Marylan	-	artment of h		Mental Hy	giene Reg. N2 0 0 6	31711
Physici	an	Decedent's Name (First, Middle, Last	it)	5	oune.	2	2. Date of De Month OC+.	Day Year	C14
/Medio Examir		4a. Facility Name (If not institution, give	street and number)			or Location of De		4c. County of De	P
Exami	iei	Johns Hopkins B.	. /: /	eater	Baut	more			
Funeral Director		5. Social Security Number 6. Se		ast birthday)	If Under 1 Year Months Days	If Under 24 H		ay, Year) (irthplace (State or Foreign Country) ryland
D		Usual Residence of Decedent	100 Cib	, Town or Lo					10d. Inside City Limits
show	'n	MD Balti		altim					1 Yes X No
the M	Director	10e. Street and Number		- CIN	10f. Zip Code			10g. Citizen of What 0	Country?
with Sa or		826 South Old	d North Poin	t Rd.		24		USA	,
death ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.				(Specify Yes or No erto Rican, etc.)		nerican fridian,
ING 21215-0036 be filed within 72 hours after death with the Maryland hal Hygiene. Indicate then "neturel", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Fun	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:	1	if Yes, specify Cub 1 ☐ Yes 232 No		erto Rican, etc.)	Specify: W	
5-0036 72 hours at netural; or deal Exam		15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busines	ss/Industry
Pin 7	Completed	(Specify only highest gra	de completed) College (1-4or 5+)		kind of work done DO NOT use retire	during most of w	vorking		
d 2121 filed within Hygiene. other then	Con	12th		Home	maker			own home	<u> </u>
Maryland d 2 should be file th and Mental Hy i' is marked oth traumatic event	Be	17. Father's Name (First, Middle, Last)						e, Maiden Sumame)	
should be nd Menta marked imatic ev	70	Edward T. Sull		10b Mailie	an Address /Street			Bittner Der, City or Town, State	Zin Code)
Mal d 2 st d 2 st th and t7 is r traur		Mete Sonmez /	•	1				nt Road E	
Te,		20a. Method of Disposition	20b F	lace of Disno	sition (Name of natory or other pla		Date	20c. Location - City	
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Baltimore, Marylar permit. Pages 1 end 2 should by Deperment of Health and Menta Important: If Item 27 is marked any njury or other traumatic enones.		21. Signaturo of Funeral Service Licen	1588	///	2. Name and Addre			e Ave. Ba	
		23a. Fart1. Enter the disease, or companies shock, or heart failure. List only	plications that caused the deat	n. Domot ent	ter the mode of dyi	ng, such as card	Tal Hom iac or respiratory a	e of Esse	Approximate
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Examiner		Supportable let conditions	6 GRATICE	134	nass &	urae Ru			13 mayers
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and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	Uence of):	esit				00.000
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687 ificate g phys as the	edic		_ d						
Box 66 eath certific ettending pl	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc			23d. Date of c	
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed this certificate hes been signed by the ettending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d		Other (specify)	;y		Month	Day Year
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Records, he law requires t e hes been signe age 2 should be o	ed by						1 🗆	Yes 2□No 3□	Probably 4 Honknown
ecord law requir as been si 2 should l	Completed	2)					24a. Was		autopsy findings available o completion of cause of
Re(The lav	E O							ormed? death	?
ita	Bec	25. Was case referred to medical examiner?				26. Place of D	Death (Check only	one)	
hysic his ca	2	1 ☐ Yes 2 ☐ HO		ER/Outpaties	III JUDON			idence 6 Other (S)	pecify)
ing P	<u></u>	27. Manner of Beath 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury occurred	
Vision Attending or death. ector: Aftel by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	9 280 Place of Injuny At h	ome farm st]Yes 2 □No	28f. Location	(Street and Number or	Rural Route Number
Division of Vital to attending Physicien: after death. Director: After this certificel	Certification:	4 Homicide determined	building, etc. (Specia	(y)	out, radiory, office			own, State)	
Division of Vital Re To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical C		ysician: To the best of my kno niner: On the basis of examina and manner stated.						
To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Md	onth, Day, Year)
- s - o		Denniler L	recen MD		RES	-000		Oct. 4 12	2006
6		30. Nam and address of person who	completed cause of death (Iter	n 23a) (Type,		***************************************			
(Jenniter know		EA	SLERN A	VE, B	Mikmone	and i	21224
St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 0 5 2006	32. Registrar's Signa	Cont					

DHMH 17 Rev 1/2001

OFIGINAL

06-07375 Derrick Szykja

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		tificate of Death		Reg No 20	06 31712
Physician/ Medical Examine	Decedent's Name (First, Middle,t Derrick	Joseph	Szyjka		te of Death nth Day Year tober 1, 2006	3. Time of Death 1014 hrs
Allege e de	4a. Facility Name (if not institution,	•	4b. City, Town,	or Location of Death	4c. County of	Death
	Bon Secours Hospital 5. Social Security Number 6.	Sex 7. Age (In yrs Ia	st birthday) If Under 1 Yo	ear If Under 24Hrs 8. D	N/A eate of Birth (MM/DD/YYYY)	Birthplace (State or
Funeral Director	213-82-9350	X M 2 F 31				Foreign Country) Maryland
any	Usual Residence of Decedent 10a State 10b County	10c. City,	Town or Location			10d Inside City Limits
<u> </u>	Missouri Boone	Co.	lumbia			1 Yes 2 X No
he Maryland t or 28a-f sh iffed at once	10e. Street and Number		10f. Zip Code		10g. Citizen of Wha	it Country?
vith the s 23a o	6301 East Breez	zewood Drive		202 Hispanic Origin? (Specify)	USA Yes or No- 14. Race -	American Indian, Black,
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once are other traumatic event, the Completed by Funeral Director	1 Never Married 2 Marr		If Yes, specify Cub	an, Mexican, Puerto Rican		white
nours aft natural* xamine	15. Decedent's Education (Specification)		16a. Decedent's Usual Occup during most of working I		one 16b Kind of Busi	iness/Industry
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Computer Tec	chnician	Electro	onics Company
5-0036 led within 7 Hygiene other than the Medica	17. Father's Name (First, Middle, La		obputor re-	18.Mother's Name (First,	Middle, Maiden Surname)	
11215-0036 Id be filed within 72 hours af fortal Hygiene narked other than "natural event, the Medical Examin		Joseph Szyj		Edna	Larue Route Number, City or Town.	Bentley
MD 21 In 2 should alth and Me m 27 is ma aumatic ev	Edna L. Szyjka				., Columbia,	
nore, MD 2 ages 1 and 2 shou ti of Health and N t: If item 27 is in other traumatic	20a Method of Disposition	20b. F	Place of Disposition (Name of erematory or other place)	cemetery, Date	20c. Location - 0	City or Town, State
Baltimore, permit Pages I ar Department of Her Important: If ite	4 Donation 5 Other Spec	3 Removal from State Ba1 cify:				ore, Maryland
Baltimo permit Pag Department Important: injury or ot	21. Signature of Funeral Service L	censee			on Park Funer altimore, MD	
Physician	23a Part I. Fater the disease, or co	omplications that caused the death.				
/Medical	Immediate Cause (Final disease	a Mixed Drug (Cocat		intoxication		Death
	or condition resulting in death)	Due to (or as a consequence of	·):			
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	·):			
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	·).			
		d.				
760, icate be executly physician and the burial - tra	X UNPENDED	AMENDED item#1,23	Ba,27,28a-f,perME	,g860, 10/20/06	23d Date of c	delivery
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Box 687 e death certifi the attending ed for use as t hvsician/	1 Yes 2 No 9 Unkn		other (Specify)			
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ecords, The law required rate has been signage 2 should be			<u></u>		performed? de	eath?
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n of ding P h After: After		28a. Date of Injury (Month, Day, Year)		Yes 2 No	Describe how injury occurre	d (
isio	2 Accident Investi	gation 28e Place of thiury - At he	Fnd 10:00 am	e building, etc. 28f. L	nknown ocation (Street and Numbe	r or Rural Route Number, City
Division o expital or Attending hours after death meral Director: Aft y filled in by the fune Contification:	3 Suicide 6 X Could 4 Homicide determ		ome/ recovery hou	se Bal	pr Town, State) 349 S. Limore, MD	Pulaski Street
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be C		rsician: To the best of my knowled iner:On the basis of examination a				
ro To con	29b. Signature and title of certifier	and manner stated.	29c. Lice	ense number	29d Date signe	d (Month, Day, Year)
	8 MAN	$\langle VV \rangle$	0.	C.M.E.	October 2, 2	2006
241	30. Name and address of person was Susan Hogan MD. A	why completed cause of death (Item ssistant Medical Examiner		altimore, MD 21201		
Stat	01 0 1 01 1 1 1 1 1 1 1 1	32 Paretrar's Signatu				
Registra		2006 Heren	No Marie			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Pamela Jane Tritz October 2006 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner 1939 HillTOP Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1□M 2**™**F Hours 214-88-1797 LO Yrs. Director 7-20-66 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. Pity, Town or Location 10d. Inside City Limits ASADENA 1 ☐ Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1122 Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married ☐ Yes Yes, Gi 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by r Yes, Give Year or Dates: Jh 1TE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ,MD. 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State NATIONAL GIFTS REGISTRY 10-6-06 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 o not enter the mode of dying, such 23a: Part1. Enter the disease, or condications that shock, or heart failure. List only one cause of sed the death as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final ARCINOMI Physician 5 MONTHS ETHOTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Be Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 1 🔲 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es No this certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) PARENTY Other: 4 Nursing Home 5 Residence 6 AOther (Specify) Hospital: 1 ☐ Yes 250 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To hours after death.

Ineral Director: After this

y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 ☐ Pending investigation 1 Tes 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 📆 Certifying Physiciam, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifier appliner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner etated. 29d. Date signed (Month, Day, Year) 29c. License number Signature an MD CTOBER death (Item 23a) (Type, Print) 30. Name and addre ATON ENUE DALTIHORE Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of M	larylan		artmer			and M		gien Reg. N	/	6	317	14
			Decedent's Name (First, Middle, Las	t)							2. Date of De	ath		9 6 1	3. Time of D	eath
	Physicia /Medic			Mildred A	A. Tw	illev							4, 200		7:20)A ^M
)	Examin	_	4a. Facility Name (If not institution, give	street and number)	,	4b. City	Town, or	Location of	of Death			c. County of I			
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	Funeral Director		5. Social Security Number 6. Social Security Number 217-34-0473 Usual Residence of Decedent	ox	97	last birthday, Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Jan. 10	ay, Yea	7)	Coun	ace (State or try) ngton,	
	iand ow		10a. State 10b. County		10c. Cit	y, Town or L	ocation					-		10	Od. Inside City	Limits
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	er deg	nne	11. Marital Status	12. Was Deceden Armed Forces	?	.S. 13.	Was Dece If Yes, spe	ident of H icify Cuba	ispanic Ori ın, Mexican	gin? (Spe 1, Puerto	cify Yes or No Rican, etc.)	0-	14. Race - Black, 1			
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änd	be fill be fill be off	Be	17. Father's Name (First, Middle, Last) William Kettler								<i>(First, Middle</i> h Aver		an Sumame)			
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Licen	S88	MOO:	198 R	obert	nd Addres	ss of Facility Pumph	rey	Funera Bethes	1 Ho	ome/Be	thes page	da-Che	₂ ∇y
		П	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the deat	h. Do not er	iter the mo	de of dyin	ig, such as	cardiac o	or respiratory a	arrest,	110 20		Approximate Interval Betw	een
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-	20		30. Name and address of person who													
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ORIGINAL.

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiers 006 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death ^{Day}2006 **Physician** October 5. JAMES STEPHEN WIDMAN 2:30A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 6 Caveswood Lane Baltimore Owings Mills If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. November 17-1945 5. Social Security Number 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) **Funeral** XXX 2 F 047-36-0175 California 60 Yrs. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e.4 **-- ery injury or other traumatic event, the Markette. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 Yes 2 No Directo Maryland Baltimore Owings Mills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21117 6 Caveswood Lane USA Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1ATVes 2 □ No Vietman If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Broker Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Widman Joan Dixon 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Coffin Widman 6 Caveswood Lane OWings Mills Maryland 21117 Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 XX remation 3 ☐ Removal from State 20c. Location - City or Town, State GreenMount Crematory 10-6-06 Baltimore, Maryland □Donation 5 □Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Signature of Funeral/Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) **Physician** Chal ang iocarcinoma 482MS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) by Physician/Medical ate has been signed by the attending phys page 2 should be detached for use as the IF FEMALE: 23c. If yes, ourcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 DEctopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 25 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Hospital: 1 ☐ Inpatienf 2 ☐ ER/Outpatienf 3 ☐ DOA Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D10718 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 GREENE REE Rd. Swi HARRY M. WALEN M.D 32 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 6 2006 Registrar

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State of Maryland /	Department of Health	and Mental I	Hvolene II	11	n	.) !		-	ľ
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			1 - State Registrar		Cert	tificate of	Death		Reg. No.		01710
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	/Medic		Helen R. Weber					00000	_	2000	9 12 PM
	Examin	er	4a. Facility Name (If not institution, give street and			-	Location of Death		4c.	County of Deat	th
			Johns Hopkins Bayvi 5. Social Security Number 6. Sex	7. Age (In yrs. last birti		Balti:		8. Date of Birt	th.	N/A	thplace (State or Foreign
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	r 288	Director	10e. Street and Number	12420111	010	10f. Zip Code			10g. Cit	izen of What Co	ountry?
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	ems ems	Funeral		ecedent Ever in U.S. Forces?	13. W	as Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit	
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Mary	2 shou and M Is mar		19a. Informant's Name/Relationship (Type, Print) Harry Weber				and Number or Rur Street	al Route Numbe	er, City o	r Town, State, 2	
a)	is 1 and of Health item 27 other to		20a. Method of Disposition	20b. Place of	Disposi	ition (Name of	!	Date		ocation - City or	
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A	Deparent Deparent Brand in Bra		Mailes Saisonou	ski							MD 21222
Н			232 Part1. Enter the disease or complications the	at caused the death. Do no	ot ente	r the mode of dyin	g, such as cardiac	or respiratory a	rest,		Approximate Interval Between
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	/Medical		resulting in death) Due	to (or as a consequence or rosuc Ost	f):						
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	274 <u>2</u>	Examiner	if any, leading to immediate Due cause. Enter Underlying Cause (Disease or injury	to (or as a consequence o	f):						
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	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funeri	edical	29a. Certifier 1 2 Certifying Physician: To (Check only one) 2 Medical Examiner: On the and m	the best of my knowledge, e basis of examination and anner stated.	death (Vor inve	occurred at the timestigation, in my of	ne, date and place, pinion, death occuri	and due to the ed at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
	To the within To the comp	W	29b. Signature and title of certifier			29c. License				e signed (Monti	
			I prace a. Corottem	Δ		035	763	6	Defo	ber 3	,2006
	5		30. Name and address of person who completed of	ause of death (Item 23a) (1 505 Hopkins	Гуре, Р	rint)	Pirle .	Beltim	ore	nd 2	12006
	Sta Registr	-		2. Begistrar's Signature)				
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			For State Registrar	Stat	e of Ma	aryland	/ Depa <i>Cen</i>	rtment of F cificate of	lealth Deati	and M h	ental H	ygiene Reg. No.	2006	3171	7
	Physici		Decedent's Name (First, Leon Young	Middle, Last)							2. Date of D Month 10	eath Day 02		3. Time of Death	M
9	/Medic Examin		4a. Facility Name (If not insi	-	nd number)			4b. City, Town, o		n of Death		T	County of Dear		
	Funeral Director		5. Social Security Number 578–42–7794	6. Sex	7. Ag e	73 (In yrs. last	birthday) _ Yrs.	If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. Min.	8. Date of B (Month, D 12-18-	ay, Year)	Co	hplace (State or Fore buntry) ington, D(
	yland		Usual Residence of Deceder 10a. State 10b. C			10c. City, T	own or Loc	ation						10d. Inside City Lim	
	Se-fel	ctor	DC			Washi	ngtor	T						XXYes 2□f	No
	death with the Maryland me 23a or 28a-f ehow r mas be notified at	i Dir	#21 Rhode Is:	Land Avenu	e NW			10f. Zip Code 20001				TOG. CIN	izen of What Co USA	ountry ?	
-0036	` ₽ 🖺	ed by Funeral Director	11. Marital Status 1 Never Married 22 3 Widowed 4 Div	Married Am	Decedent Bed Forces? Yes 2 Nes, Give r or Dates:	10	lf 1	las Decedent of H Yes, specify Cub	an, Mexic	an, Puerto	ecify Yes or N Rican, etc.)		14. Race - Ame Black, Whit Specify: B1 ind of Business	e, etc. ack	
21215	iene. r then "nat	Completed		highest grade compl	eted) ege (1-4or 5		(Give k life. D	ind of work done O NOT use retire	durina m	ost of worki	ng			arch Lab	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygene Importent: If Item 27 is marked other then eny Injury or other traumatic event, the Magnee.	To Be C	17. Father's Name (First, M Richard Young			,				her's Name	(First, Midd.	le, Maiden	Sumame)		
Aary	2 should had had had had returned	W }	19a. Informant's Name/Rel		t)			Address (Street							
	tem 27		Fannie Young	Wile	·	20b. Plac	e of Dispos	hode Is ition (Name of atory or other pla			e NW,		ocation - City or		
Baltimore,	Pages nent of ent: If I		1 X Burial 2 □ Crem 4 □ Donation 5 □ Ot		from State	_	-	Nationa Nationa		10-12	-06	Tr	iangle,	VA	
SA Balt	permit. Departimporti		21. Signature of Funeral S	A h M a	00		22.	Name and Addre	ess of Fac						÷
9 0	Physician /Medical		23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	List only one cause	on each lin	10.	nohe	•	ng, such				w, wasn	Approximate Interval Between Onset and Peath	5.5
12/06	icate be executed by physician and sthe burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	**	`	a consequer									
) (C)	. Ξ Ο α	Physician/Me	IF FEMALE: 23b. Was decedent pregnain the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	? 1 <u>0</u>	Live birth	of pregnancy 2 Fetal de time of deat	ath 3 🗌	Ectopic pregnanc Other (specify)	у				23d. Date of de Month	livery Day Year	
λγγ rds, P	quires that in signed I	b	Part II. Other significant co	onditions contributing	g to death bi	ut not resultii	ng in the un	derlying cause gr	ven in Pa	rt I.		tobacco u Yes 2		o the cause of death?	
V 0 ℃	The faw requires ate has been sign page 2 should be	Completed									24a. Wa aut per 1 🗀 Yes	topsy rformed?	death?	utopsy findings availa completion of cause of	ble of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to mexaminer?	nedical Hospital:				_ · · · · · Ott	hac		Check on		-	Marake	2 .
Leor Division of	ding After fune	Certification: To	2 ☐ Accident i	Pending nvestigation	Date of Injui (Month, Day	y Year)	Bb. Time of Injury	28c. Inju Wo	ry at rk?] Yes 2	□No		e how injui	nd Number or R	ural Route Number,	
_	To the Hospital or Attend within 24 hours after death To the Euneral Director: completely filled in by the	edicai C	29a. Certifier 12 Ce (Check only 2 Me	ertifying Physician: on adical Examiner: On and	To the best of the basis of manner sta	f examination	edge, death n and/or inv	occurred at the ti estigation, in my	ime, date opinion, d	and place, leath occurr	and due to the	e, date and) and manner a d place, and du	s stated. e to the cause(s)	
	To the within To the comp	M	29b. Signature and Rhanf	certifier				29c. Licen:	se numbe	or Les se		29d. Da	te signed (Mon	th, Day, Year)	
	4		30. Name and address of p	erson who completed	V	eath (Item 2	3a) (Type, I		417	D		Oct	ober 2,	200b	
V	Sta		31. Date filed (Month, Day,	Year)	SOICE 32 Registra	ar's Signatur	N.E	w s	T	Dalt	mole	M	7 211	01	
	Regist	al	0016	, 5 2000		" الرائلو حي	AND THE								

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Thelma 09 1300 M Africa 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Braddock Campus Allegany WMHS Cumberland If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Aug 30 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1945 Months 1 □ M 2 1 F 236-68-4228 Aug Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits worle rthen "naturel", or Items 23a or 28a-f ehov the Medical Examiner must be notified at 1 Yes 2 No Allegany Director Mt. Savage 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 14208 Lower Sunnyside Rd. NW 21545 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 ☐ Xio þ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene Homemaker Own Home marked other permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked other arty injury or other treumatic events. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Imes Dorothy Pearl (Gordon) Imes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel R. Africa, Sr. 14208 Lower Sunnyside Rd NW, Mt. Savage, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Rest Lawn Mem Gard Oct 3 06 LaVale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hafer Funeral Service, 21. Signature of Funeral Service License 1302 National Hwy., LaVale, MD 21502 Hohn Na 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) CERE BROVASCULAR ACCIDENT **Physician** /Medical Examiner -17 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ed by the attending physicien end detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 Yes 2 No 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificete 1 ☐ Yes 2 🗓 1 Yes 2 No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 SNo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 2 ER/Outpatient 3 DOA 2 this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral i 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 Tyes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. Ę 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 SEPTEMBER 28, 2006 096907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishop Walsh Road Cumberland Manyland 21502 State Registrar

		-	1 - State Registrar Amend#5.Per	State of Marylan					Mental	Hygier	2006	31	719
G.	. &		Decedent's Name (First, Middle, Last)	111 100 3 20 0	0001001	111100		504111		of Death		3. Time	of Death
	Physicia /Medic		LENA MAY AUSTIN						Sep		19, Year	06 7:3	0 a ^M
	Examin	er	4a. Facility Name (If not institution, give s			4b. Cit	y, Town, or	Location of Death	1		tc. County of Deal	_	
	Francis		9114 Annapolis Ro 5. Social Security Number 6. Sex		last birthday)	If Und	nham er 1 Year	If Under 24 Hrs.	_ 8. Date	of Birth	Prince Ge		S te or Foreign
	Funeral Director			м 2ДF 100	Yrs.	Month	Days	Hours Min.		9, 19		_{uintry)} ginia	
	and W		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	v. Town or Lo	cation						10d. Inside	City Limits
	Maryli fed a	tor	Maryland Prince Ge	eorge's Lan	ham								es 2 □ No
	th the	Director	10e. Street and Number			10f. 2	ip Code			10g. (Citizen of What Co	untry?	
	eth wi		9114 Annapolis Roa				0706				U.S.A.		
_	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	 Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No 				ispanic Origin? (S In, Mexican, Puert	pecify Yes o Rican, e	or No- tc.)	14. Race - Ame Black, Whit		,
9200-91212	d within 72 hours after deeth with the Maryland sien. Jene. Than "natural", or Itema 23a or 28a-f show the Medical Examinat must be notified at	by	3 X Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2 X No	Specify:			Specify: Wh	ite	
Ų Ö	72 ho "natur olicel	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	kind of v	vork done o	durina most of wor	king	16b.	Kind of Business	industry	
7	within 72 ene. than "na	Jupi	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen		use retired	3)		Or	vn Home		
	be filed htal Hygie od other event, tt	Be Co	17. Father's Name (First, Middle, Last)		Homen	ianc.		18. Mother's Nan	ne (First, I				
Maryland	es 1 and 2 should be filed w of Heelth and Mental Hygier If Item 27 Is marked other th rr other traumatic event, the	To B	Ernest Frenzel					Claire	Crou	ch			
Jan	12 sho		19a. Informant's Name/Relationship (Typ		1	•					y or Town, State, 2		
αĵ	1 and Heelth Ism 27	i i	Clifton L. Austin 20a. Method of Disposition		Place of Dispo semetery, cren				cown, Date		Land 2065 Location - City or		•
ē	Pages ent of nt: If II		1 Burial 2 □ Cremation 3 □Re 4 □ Donation 5 □ Other (Specify)	amovat from State	emetery, crer t Linco			1 -	2/200	6 B1	entwood,	Mary	land
Baltimore,	permit. Pages Department of I Important: If Its any Injury or of once.		21. Signature of 5 meral Service License		22	. Name	and Addres	ss of Facility G	asch'	s Fune	eral Home	, P.A	. •
n	89 = 8		Value Ties	170137	-						ville, MI		
		0 0	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.				g, such as cardiad	or respira	itory arrest,		Approxi Interval Onset a	nate Between nd Death
	Physician /Medical		disease or condition resulting in death)	Congestive		fa	llure						
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	ב פ	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):								
	and and I-trans	Examine	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):								
8760,	cate be executed physicien and the burial-transit	dical E	L _d										
D		Medic	IE EENALE.										
. Box	death certifi e attending I id for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	il death 3□		pregnancy	,			23d. Date of de Month	ivery Day	Year
	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d 9☐Unknown	leath 5L	Other	specify)		30,				
Э,	law requires that the as been signed by th 2 should be detache	y Ph	Part II. Other significant conditions con	tnbuting to death but not res	ulting in the u	nderlying	g cause giv	en in Part I.	236	. Did tobacc	o use contribute to	the cause	of death?
rds	w require been sig should b		Aspiration pneur	monia						1 🗌 Yes	24 No 3 □ P	obably 4	□Unknown
မင် ပ	law re las be	Completed							24a	. Was an autopsy	24b. Were at	topsy findir	igs available of cause of
E E	sicien: The law certificete has t irector, page 2 s									performed? Yes 2X		2 □ No	
<u> </u>	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 X No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3	Oth Oth	er: 4 Nursing b			6 □Other (Spe	crés l	
o	ding Phys h. After this c funeral dir	n; To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injur		1		ijury occurred	city)	
Sio	r Attendir er death. rector: Af by the fur	catic	1. ■ Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			М	1 🗆	Yes 2 □ No					
Division of Vital Records,	f or Attendated after death Director:	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, far <i>m</i> , str fy)	eet, fact	ory, office			ation (Street or Town, St	and Number or R ate)	ural Route I	lumber,
_	To the Hospitet or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the fune.		29a. Certifier 1 X Certifying Phys	icien: To the best of my kno	owledge, deat	h occurre	ed at the tir	me, date and place	, and due	to the cause	(s) and manner a	s stated.	
	To the Ho within 24 To the Fu completel	ledicai	one)	er: On the basis of examina and manner stated.	ation and/or in				irred at the				
ı	To	2	29b. Signature and title of gertifier	i		2	29c. Licens D55				Date signed <i>(Moni</i> September	-	
Δ	(6)		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type.	Print)					P - C III C I		
K	_(0)		Thomas Maslen, MD	7525 Green	ıwav Ce	nte	Dri	ve, #316	, Gre	enbe1t	, MD 207	70	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 2 2006	2. Registrar's Sign	ture	Les .							

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** GEORGETTE September 21 2006 ALLEN 2:15 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🗔 F 91 075-14-0818 Director New York Mar 21, 1915 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits I? le marked other than "natural", or Items 23a or 28e-f ehow treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Frederick Maryland Frederick Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21702 7401 Willow Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 72 hours after 10 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White à 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. In end Mental Hygiene 7 ie marked other than "nu Elementary/Secondary (0-12) College (1-4or 5+) County Library Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bissell Carl Polly Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health enc Important: If Item 27 le rr eny injury or other treurr 2002. John Allen/Son 1210 Pinewood Dr. Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockville Cemetery 9/24/2006 Rockville, MD 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, Md 21702 23a. Par 1. Enter the disease, or a implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or hand failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) May **Physician** Duodena) Ulcer tocated /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine hed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 ☐ Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred sal or Attending P s after death. Certification: Injury Natural 5 Pending 1 Yes 2 No 2 Accident investigation

State Registrar

6 Could not be determined

Cline

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

3 Suicide

(Check only

29b. Signature and title of certifier

Casper

To the Hospital within 24 hours at To the Funerel D

Medical

Estifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MDD16428

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

300 West Ninth Street

agistrar's Signatur

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. NZ UU6

3. Time of Death

2. Date of Death

Month **Q Physician 22 JOHN** K. AXEL 2006 03:04 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10–10–1938 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. 1**★** M 2□ F 67 Yrs. 326-32-5769 ILLINOIS Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exambles must be codified at 1 Yes 2 No DELAWARE SUSSEX Director OCEAN VIEW 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19970 UNITED STATES 37311 SKIPPER PLACE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 図 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE Specify: <u>6</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ADVERTISING SALES ADVERTISING permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linky or other traumatic event page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLOTTE HOFF CHARLES W. AXEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 37311 SKIPPER PLACE, OCEAN VIEW, DE 19970 JUDITH A. AXEL/ WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CAPE HENLOPEN 3 ☐Removal from State Other (Specify) 9-23-2006 FRANKFORD, DELAWARE CREMATORY MELSON FUNERAL SERVICES, LTD. WEST AVE., OCEAN VIEW, DE 19970 Part 1. Enter th lease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ture. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart fa Immediate Cause (Final disease or condition resulting in death) **Physician** CAPILLARY LEAK SYNDROME /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 NO 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Aftar 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and tyle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064120 MI D

DHMH 17 Rev 1/2001

State

Registrar

BA 2

1 - State Registrar

1. Decedent's Name (First, Middle, Last)

Healthway Drive, Berlin MD

address of person who completed cause of death (Item 23a) (Type, Print)

33

Registrar's Signature

Zershan, Ati

SEP 2 5 2006

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Marylan		irtment of F			giene Rog. NG. (006	31722
	Physici		1. Decedent's Name (First, Middle, Las	•				2. Date of Dea Month	Day	Year	3. Time of Death
	/Media	al	Kathryn Marie 4a. Facility Name (If not institution, give	Achstetter		4h City Town o	r Location of Deat	-		16, 2006 ounty of Death	4:45p M
1	Examir	er	, , , , , , , , , , , , , , , , , , , ,			-	lphi	1		ince Geo	raols
	Funeral		Hillhaven Nursin 5. Social Security Number 6. Secu	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h	9 Birthola	ace (State or Foreign
	Director		150-09-7568	□M 3√2F 90	Yrs.	Montais	110013	Feb. 11		16 Penns	ylvania
	ow ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	Od. Inside City Limits
	Mary B-1 sh	tor	Maryland Prince	George's	Ве	eltsville)				1 ☐ Yes 2 🛣 No
	h with the 23a or 28 at be not	ai Director	10e. Street and Number 10505 Woodleigh	Court		10f. Zip Code		20705	10g. Citize	en of What Count	try? USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic avant, the Modical Execultrate and be muffled at once.	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 1 No	lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)		Race - America Black, White, e pec White	
9-10	72 hou	ted	15. Decedent's Ed	ucation	16a. Deced	lent's Usual Occup	pation	tking	16b. Kind	d of Business/Ind	ustry
21215-0036	within 7 ene. than "n	npie	(Specify only highest gra	College (1-4or 5+)	life. L	kind of work done OO NOT use retired	d) -	Kirig		0 #	
	lled w Hygier ther th		17. Father's Name (First, Middle, Last)			Homemake	_	ne (First, Middle,	Maiden Si	Own Ho	me
Maryland	should be f nd Mental h rmarked of umatic ava	To Be	Arthur B. Campbe	11				Bridget	Sarah	h Roddy	
Mar	d 2 sh h and 7 is m traum		19a. Informant's Name/Relationship (7			g Address (Street					
	Heall tem 2 other		Kathryn Jeanne C 20a. Method of Disposition	20b. P	lace of Dispo:)5 Woodle sition (Name of	1	Date		ation - City or Tov	
E O	Pages nent of ant: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State C+		natory or other plac Cemetery	- DEUL	. 21, 06	Wash:	ington,	DC
Baltimore,	permit. Departm Importe any inju		21. Signature of Funeral Service Licen	SOO CO	E	Name and Addre	ss of Facility Collin	s Funera	al Hon	me Inc.	, MD 20901
8760,	Certificate be executed ding physician and chinal-transit eas the burial-transit	icai Examiner	23a. Part. Enter the disease, or comy shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Disco for as a conseq c. Due to (or as a conseq d.	uence of): uence of): uence of):	tion tion t, Er	nd-S	tage)		Approximate Interval Batween Onset and Death Week Months
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rds, P	es this	by	Part II. Other significant conditions of	ontributing to death but not res	ulting in the ur	nderlying cause giv	ren in Part I.	23e. Did to		contribute to the	e cause of death? ably 4 Unknown
Records,	elaw hasb je 2 si	Completed						24a. Was autop perfo 1 Yes	an sy ormed?	prior to com death?	osy findings available inpletion of cause of
Vital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o		/ /	—
of V	ding Physician: h. After this certific funeral director,	P	1 ☐ Yes 2 No		ER/Outpatien		4 Nursing F	lome 5 Resid)
on o	ling After fune	inoi	27. Manner of eath Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat nk? Yes 2 ∐ No	28d. Describe	now injury o	occurred	
Division	or Attanding ifter death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined				163 2 140	28f. Location (S City or Tox	Street and I vn, State)	Number or Rural	Route Number,
Ω	To the Hospital or Attanc within 24 hours after death To the Funeral Director: completely filled in by the t	edicai Ce		ysician: To the best of my kno niner: On the basis of examina							
	To the H within 24 To the F complete	Medi	29b. Signature and title of certifier	and manner stated.	7	29c. Licens				signed (Month, E	
	8 4 2 4		E. Monia	1. (Brance Co	1000	Do	7524	-01	Som	bushow	-20 2M
1	J		30. Name and address of person who	completed cause of death (Item	1 23a) (Type.	Print)	7 7 7	14	1/2	STUPYS	DO no MI
			VThomas	Annulis, M.	D. 108	80/Lock	wood Dr	ive #20	5	209	101
	Sta Regist		31. Date filed (Month, Day, Year) SEP 2 1 2	32 Registrar Signa	ture /	ule)	7	

			For State Registrar	State of Maryland		artment of I			giene Reg. N2 0 0 6	31723
*	50	<	Decedent's Name (First, Middle, Last	st)				2. Date of Dea	ath	3. Time of Death
	Physicia /Medic		Mary Cat	herine Abell				Month Septemb	er 26, 2006	7:42 P M
	Examin	3.5	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of E	Death	4c. County of Dea	ath
	S	All I	44265 St. Andrew			Califo If Under 1 Year		Hrs. I a a (B)	St. Mary	
	Funeral		5. Social Security Number 6. S	ex	ast birthday) Yrs.	Months Days		Min. (Month, Da	y, Year) 9. Bil	rthplace (State or Foreign ountry)
wj 4	Director		213-78-4592 Susual Residence of Decedent					November	22, 1915 Man	Lyland
	yland how		10a. State 10b. County		, Town or Lo					10d. Inside City Limits
	e Ma	cto	Maryland St. Ma	ry's Cal	iforni	a				1 ☐ Yes 2 No
	vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	eath v	erai	44265 St. Andrew	's Church Road	S 13	3	20619	2 (Specify Yes or No.	USA - 14. Race - Am	encan Indian.
	fter d	Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No				? (Specify Yes or No Puerto Rican, etc.)		ite, etc.
8	al', o	þ	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	Specity:		Specify:	White
2	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show a Medical Examber must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occu	durina most o	f working	16b. Kind of Business	s/Industry
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io D	filed wii Hygien other th		17. Father's Name (First, Middle, Last)		11011	Cinaker	18. Mother's	Name (First, Middle,	Maiden Surname)	
au	id be ental ked o	To Be	George F. Guy				Mary	Ellen Tu	rner	
Maryland 21215-0036	2 should be and Mental Is marked aumatic av	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Stree	and Number	or Rural Route Numbe	er, City or Town, State,	Zip Code)
	and 2 ealth a m 27 ls		Mary Catherine B	os / Daughter	P.O.	Box 416,	St. Ma	ry's City		
more,	of H of H		20a. Method of Disposition 1 ABurial 2 Cremation 3 C	Damayal from State	emetery, crei	natory or other pla		Date ptember	20c. Location · City o	
Ξ	Pages tment of tant: If It tant: or o		4 Donation 5 Other (Specific	y) HQ	7	e Cemete	ry	30, 2006	Great Mill	s, Maryland
Bai	permit. Pag Department Important: I any injury o once.		21. Signa are of Funeral Service Licer	Hardiner	M F	0.0. Box 27	Gardiner O. Leona	Funeral Homordtown, MD 2	0650	
69			23a. Part 1. Enter the disease or com shock, or heart failure. List only	plinations that caused the death	n. Do not en	ter the mode of dy	ng, such as ca	rdiac or respiratory ai	rest,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	. 1	,	0		1.5
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	ted nsit	nine	Cause (Disease or injury	Ila ne b	a ence on.	V				10 4000
,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to towas a consequ	uence of):	771_	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -			10 feets
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	res that ti igned by be detac		Part II. Other significant conditions of	contributing to death but not resi	ulting in the u	ınderlying cause g	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
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Ö	aw requir s been si 2 should	Completed	Chung-	betweether	lun	or die	ext.	24a. Was		autopsy findings available
Ä	The lay	mo				0		autor perfo	rmed? death?	
İta	ician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place o	f Death (Check only o		
<u>></u>	Physic this ce al dire	2	1 ☐ Yes 2 € No	L		nt 3 DUA		ing Home 5 Resi		ecify)
nc On C	After After funera	ion:	27. Manner of Death 11☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	We	nyat ork?]Yes 2∐No		how injury occurred	
Division of	death ctor: /	licat	2 Accident Investigatio 3 Suicide 6 Could not b	Ban Blace of Injury - At he	ome, farm, st				Street and Number or F	Rural Route Number,
Ö	ital or A rs after al Directed in by	Certification:	4 Homicide determined	building, etc. (Specify	y)			City or To	wn, State)	
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	edical		nysician: To the best of my kno miner: On the basis of examina and manner stated.						
	To the To the Comple	Me	29b. Signature and title of certifier	ă-		29c. Licen	se number	,	29d. Date signed (Mor	nth, Day, Year)
)			Rita B.	haver-		100	3265	(9/27/06	+ Africa
			30. Name and address of person who	completed cause of death (Item	1 23a) (Type,	Print) Ex	planch	ion-Blog	#1035一	200 == 2
1000			21 Data filed (Month Day Vasr)	32. Egistrar's Signa		335. 7	exing	ten Par	le mi	20653.
	Sta Regist		31. Date filed (Month. SEP P 2 9	2006	A .	book				

			1 - For State Registrar	State of Maryla		artment of rtificate o			giene Reg. n 2 0 0 6	31724
	Physici	an	Decedent's Name (First, Middle, Last)				_	2. Date of Dea Month	Day Yeer	
	/Medic	al	Minnie B. Alde 4a. Facility Name (If not institution, give s			4b. City. Town	, or Location of Do	eptember	20, 200 4c. County of Dea	
	Examin	er	5 Stoney Chase			Elkt			Ceci1	
	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Yea Months Day	ar If Under 24 h	Hrs. 8. Date of Birt (Month, Day	h 9. Bir	rthplace (State or Foreign
ш	Director		Usuel Residence of Decedent	M 27 F 92	2 Yrs.			June 8,	1914 NOL	cn Olina
	yland sow		10a. State 10b. County	10c.	City, Town or Le	ocation				10d. Inside City Limits
	e Mar	ctor	Maryland Cec	il I	Elkton					1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	eath v	eral	5 Stoney Chase 11. Marital Status	Drive 12. Was Decedent Ever in	118 13		921	/Specify Ves or No.	USA 14. Race - Am	erican Indian
က	or Item	Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	1			(Specify Yes or No- uerto Rican, etc.)	Black, Whi	ite, etc.
ğ	ours a	d by	3 XWidowed 4 □ Divorced	If Yes, Give A Year or Dates:		1 ☐ Yes 2 🙀 N	lo Specify:		Specify: W	nite
21215-0036	n 72 h "natu adica	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during most of	working	16b. Kind of Business	s/Industry
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פ	al Hyg other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's i	Name (First, Middle,		
<u>Ya</u>	ould b Menti mrked arked	To I	John Lewis Sutt						ne Holder	
Maryland	d 2 sh th and 7 la m traum		19a. Informant's Name/Relationship (Ty) Agnes M. Davis,						ton, Md.	
ē,	s 1 an f Heal itam 2 other		20a. Method of Disposition	_	o. Place of Dispo	osition (Name of		Date	20c. Location - City of	r Town, State
Ë	Pages nent o int: If iry or		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State Gi	lpin N	matory`or other p Manor M	lem. 9/	25/06	Elkton, 1	Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23s or 28s-f ahow any injury or other traumatic avant, the Medical Examinar must be notified at once.		21. Shaature of Propert 5, pice License	90	And	2. Name and Ado Trew G.	Gee		E. Main	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the di		neral H ter the mode of d			ton, Md.	21921 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Len						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
	j.	er	Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying	Die to (or as a nons	Sectioning of):					
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Box 6	leath certifica attending ph d for use as th	√Me	IF FEMALE: 23b. Was decedent pregnant	3c. tf yes, outcome of pre-					23d. Date of de	alivery
Ö	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ F 4 □ Pregnant at time o 9 □ Unknown		∃Ectopic pregnar ∃ Other (s <i>pecify)</i>			Month	Day Year
<u>α</u>	that the		Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause	given in Part t.	23e. Did to	bacco use contribute t	o the cause of death?
rds	w requires to been signer should be	ed by						_ 1 🗆 Y	′es 2,Deno 3□P	robably 4 Unknown
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<u>~</u>	: The cate h	Con						perfor	rmed? death? 2 X No 1 ☐ Ye	_
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ō	g Phys er this eral di	-	27. Manner of Death	1 Inpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatier 28b. Time o	II JU DON	4 🗀 14013111		lence 6 Other (Spenow injury occurred	ecify)
Ö	Attending Ir death.	atlo	1 Natural 5 Pending 2 Accident investigation	(Mona, Day real) Injury		Tonk? ☐Yes 2☐No			
Division of Vital Records,	al or Attanss after deat	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)	reet, factory, office	e	28f. Location (S City or Tow	Street and Number or R vn, Stale)	lural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical (29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	sician: To the best of my later: On the basis of exame and manner stated.	knowledge, deat ination and/or in	h occurred at the vestigation, in my	time, date and pl opinion, death o	ace, and due to the occurred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	\cap)		nse number		29d. Date signed (Mon	
}	. 1		1 /mse	ande	\sim	Do	0261	83	Sept. 2	0,2006
	4		30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type,	Print)	1 1	NouTh	Fait m	0,2006 d 21901
	Sta	te	31. Date filed (Month, Day, Year) SEP 2 2 2006	/32. Registrar's Si	nature	Mai CC	ii /tue) / 00 (1)	-RJI 11(w 21/01
	Registr	ar	SEP 2 2 2006	Steen L	400					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2. Date of Death Month 3. Time of Death **Physician** 10:42 PM E Baker 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Manulana Battimore Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Apr. 29, 1952 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F 54 Pennsylvania Director 184-42-5213 Usual Residence of Decedent 2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other then "nature!', or Items 23a or 28a-1 show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 ie markad other then "naturel", or iteme 23a or 28a-1 ebov other traumatic event, it a Macilcal Examinar must be notified at 1 ☐ Yes 2 No Hustontown Director Fulton Pa. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17229 U.S.A 8810 Waterfall Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Peges 1 and 2 should be Department of Health and Menta Important: If Item 27 1s marked ery injury or other traumatic ery 2002. Mary A. Jones Edwin R. Baker ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leona Baker (Wife) 8810 Waterfall Rd. Hustontown, Pa. 17229 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a Method of Disposition Sept.30, 1

Burial 2 □ Cremation 3 □ Removal from State Center Cemetery Waterfall, Pa. 4 ☐Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician resulting in death) /Medical Due to (or as a consequence of): Examiner month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit End Stage Liver that initiated events resulting in death) Last Due to (or as onsequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 ☐Ectopic pregnancy ŏ Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9☐ Unknown 9 Unknown ሯ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No. 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Tes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA Inpatient 27. Manner of Math ate of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 🗌 Yes 2 No 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Cal (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1678 2006 stunp, MD who completed cause of death (Item 23a) (Type, Print) Battimore MD 22 S. greene

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

OCT 0 5 2006

ORIGINAL

32 Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiere of Co.

						iai yiai i				Death		Reg. No.	b 3	1/26
	Physicia	ın.	1. Decedent's Nan	ne (First, Middle, L	ast)						2. Dete of De Month	eth Dey	Year	3. Time of Death
·	/Medic	al .				BUSHM	IAN, S	R.				BER 27,2		11:25 A.M.
	Examin	er			ve street and number)			4	lb. City, Town, or Lo		h 4c. County	of Death	
				WAYNESBO				Williada	4 1/	EMMITSB			REDER	
	uneral		5. Social Security I		Sex 7.A 15∑M 2□F		lest birthdey) Yrs.	If Under Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	9. Birthplac	ce (State or Foreign ()
Di	irector	-	218-34-2 Usuel Residence		21	68	113.				OCT.	3 , 1937	EMMITS	BURG, MD.
lend	% #		10a. State	10b. County		10c. Cit	y, Town or Loc	ation					10d	I. Inside City Limits
Men	투혈	ত্	MD	EBEUI	ERICK		EMMITS	פנזפכ						1 ☐ Yes 2 ☑ No
the c	128 128	Director	10e. Street end Nu		JAT CIC		DITITI 15	10f. Zip	Code			10g. Citizen of V	Whet Country	17
h wit	38	읖	9428	WAYNESBO	ORO PIKE				2172	27		TT C	S.A.	
deat	E 5	Funeral	11. Marital Status	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	12. Was Deceden	Ever in U	S. 13. V	as Deced		ispenic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		e - American	
after	a a	3	1 Never Mar	ried 2 Married	Armed Forces 1 Yes 2 If Yes, Give	No					Hican, etc.)		ck, White, etc	
U K I K I D-UOSO filed within 72 hours after death with the Meryland Hydiene.	3	ò	3 Widowed	4 Divorced	Year or Dates:		'	☐ Yes :	XINO	Specify:		Specify	WHITE	3
72 h	dica.	Completed	(Spe	15. Decedent's E	ducation ede completed)		16e. Deced	cind of wo	k done d	during most of work	ing	16b. Kind of Bu	usiness/Indu	stry
و <u>أ</u> أ	3	声	Elementary/Sec		College (1-4or	5+)	life. D	O NOT us	e retired	1)		VETER]	NARIA	N
Nej P	2.5	ই ∤	17.5.0.4.10	_			vet	erina	riar	tec.	· · · · · · · · · · · · · · · · · · ·	HOSP]		
De fi	\$ 0 0 0 0	Be	17. Father's Neme	(First, Middle, Las	1)					18. Mother's Name	e (First, Middle	, Maiden Suman	10)	
should nd Men	item 27 is marked other than "natural", or items 23a or 28s-f show other traumatic event, the Medical Examiner must be notified at	ဥ			VILLIAM BU	SHMAN					PORTNER			
VICE 12 SI hem	reur traur	1		leme/Relationship					•	and Number or Run				
Healt	ther 2	- 1	CHERYL 20a. Method of Dis	BUSHMAN/V	VIFE	20h P	9428 Place of Dispos	B WAY	NESE	BORO PIKE	EMMIT Date	SBURG, N 20c. Location -		
D 0	= 0 P		1 ☐ Burial 2	Cremation 3 l	☐Removal from State	, 6	emetery, crem	atory or o	ther plac	1	Date	200. Location	City of Town	i, State
it. Peg rtment	njury			5 ☐ Other (Spec	•	SM	THSBUR	1-0-2			30/06	SMITHS	BURG,	MD.
D S S S S S S S S S S S S S S S S S S S	Important: If any Injury or once.	- 1	21. Signature of F	uneral Service Lice	D. A.		22.	Name an	a Addres	ss of Facility	KILES F	UNERAL H	HOME	
			yo	Ten M.	Sheles								21727	
	23a. Perty Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											In	Approximate Interval Between Onset and Death	
	sician edical		Immediate Ceuse	/Final	1,,		C 41		_					7
	miner		disease or condition	on	e. MV	79	Cer	ice	V_					/ M/
		-				Due to (o	ras a consequ	uence of):					1	
petr	Insit	Examiner		•	b	*							- 1	
) Mac	n enc el-tre	Exa	Sequentially list of if any, leading to it	onditions, mmediate		Due to (u	ras a consequ	ierice of).						
2 8	physiclen end s the buriel-trensit	edical	Sequentially list of if any, leading to in cause. Enter Und Cause (Disease of that initiated event)	r injury	C	Due to (or	r as a consequ	ionos of):						
ije e	es th	8	resulting in death)	Last		Due 10 (01	as a consequ	ience ory.					1	-
Physician: The lew requires that the death certificate be executed	esn.	١			d									
deet	been signed by the ettendir should be deteched for use	Physician/	Part II. Other signi	ficant conditions	contributing to death I	out not resu	ulting in the un	derlying c	ause give	en in Part I.	23b. Did	tobacco use co	ntribute to th	hs cause of death?
, å	by th	ٳڿۣٙ	-					, ,			10	Yes 2□ No	3 Probal	bly 4□Unknown
s the	pe eq	ò				_								
a anima	en si ould	3									24a. Was	en eutopsy ormed?	24b. Were availa	autopsy findings
8 8	2 sh	Completed											comp of de	oletion of cause
E e	page	팃									10	Yes 2⊠NU	101	res 2□ No
i ii	ctor,		25. Was case refe examiner?	rred to medical						26. Place of Deat	h (Check only	one)		•
ysic	dire	၉	1 ☐ Yes 2 ∑	No	Hospital: 1 ☐ Inpati	ent 2 🗆	ER/Outpatient	3□ DC	A Oth	er: 4 Nursing Ho	me 5 Resi	dence 6 □Oth	er (Specify)	
- E	fter thu		27. Menner of Dea 1 ☑Natural	th 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of Injury	2	Bc. Injun Worl	y at k?	28d. Describe	how injury occur	red	
Attending ar deeth.	or: A the fu		2 Accident	investigatio				М	1 🗆	Yes 2 □ No				
r Att	Irect n by	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not l determined	200. Place of In	jury - At ho tc. <i>(Specif</i> y	ome, ferm, stre	et, factory	, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural F	?oute Number,
Is a contract of	Dell Dell													
To the Hospital or within 24 hours efte	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only	1 X Certifying P 2 Medical Exa	hysician: To the best miner: On the basis o	of exemine	wledge, death tion end/or inv	occurred a estigation,	at the tim in my o	ne, date end place, pinion, deeth occurr	and due to the ed at the time,	cause(s) and ma date and place,	nner as state and due to th	ed. ne cause(s)
the Shirt	mple		one) 29b. Signature end	title of certifier	end manner s	leted.		290	License	e number		29d. Date signe	d /Month De	v Veerl
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1	0		Neme end add	ress of person who	completed cause of	peeth (Item	23e) (Type, F	rint)	21	W Th	Stron	of From	losick	MD 2001
	Stat	. K	31. Date filed (Mor	nth, Day, Year)	32 Regist	rer's Signa	ture /		- 1	VI /	ار ال	-1 /140	V-1-1	11-1
	Otal	٠		CT 0 5 21	DOC EL		29 B.	3. B						1

			For State Registrar		State o	f Marylan	•	artment <i>rtificate</i>			nd M		giene Reg. 2 .0	06	317	27
3 . 3	Physici		1. Decedent's Name (Fi	irst, Middle, La JACF		LEE	В	OWLES	5			2. Date of Dea Month Sept.	Day	2006	3. Time o	of Death
	/Medic Examin		4a. Facility Name (If not					4b. City, T		ocation of	Death			unty of Death		
		745 2°	1422	Dalewo	od Dr:	ive		ė	Jarr			Lle		Harf		
	Funeral Director		5. Social Security Numb 220-52-46		M 2□F	7. Age (In yrs. 60		If Under 1 Months		f Under 2 Hours	Min.	8. Date of Birth (Month, Day 5/10/	1946	9. Birth Cou	place (State ntry) Mary 1	or Foreign Land
	pu *		Usual Residence of Dec	b. County		10c, Cit	y, Town or Lo	ocation							10d. Inside C	City Limits
	e Maryla	ctor	MD.		ford				Jar	ret	tsv:	ille			1 🗆 Yes	2 N O
	or 28	Dire	10e. Street and Number					10f. Zip 0	Code		001			of What Cou		
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36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menial Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 🛣		Armed For 1 Tyes If Yes, Gir	/0		was becode If Yes, specif	25	Mexican, Specify:	, Puerto i	cify Yes or No- Rican, etc.)		Black, White,		2
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	tond Health tem 27 other tr	}	20a. Method of Disposit	tion	-1-1	20b. F	Place of Dispo	sition (Name	e of	u D.		ate		ion - City or T	-	•
JOH.	0 0		1 Burial 2 Co	remation 3 E	☐Removal from		cemetery, crei View			k 1 (0/3/	2006	Sykes	svill	e. Ma	rvlar
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe		21. Signature of Funera				22	2. Name and	Address	of Facility	Jar	retts on Fun	ville	e, Ma	rylan	nd
	*		23a. Part1. Enter the d	lisease, or con	plications that one cause on e	aused the deat									Approxima Interval Be	ate etween
	Pnysician	4.1	Immediate (a ise (Final disease or condition		1/	e tusto	atic.	Col	on	0	CALL	21			Onset and	Death
	/Medical Examiner		resulting in death)	(Due to	(or as a conseq	uence of):								0	ř.
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8760,	be executed sicien and burial-transit		resuming in death) case		Due to	(or as a consec	juence of):									
687	ficate phys is the	edic			_ d											
Box	The law requires that the death certificate be executed to hes been signed by the attending physicien and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent prein the past 12 mor 1 Yes 2 No 9 Unknown	nths?	1 ☐ Live b	tcome of pregna birth 2 Teta nant at time of co own	Il death 3	Ectopic pre-					23d.	Date of delive Month	rery Day	Year
ds, P.O.	uires that the d signed by the id be detached	þ	Part II. Other significar	nt conditions	contributing to d	eath but not res	sulting in the u	inderlying car	use given	in Part I.			obacco use o	contribute to		death?
of Vital Records,	aw requir as been si 2 should I	Completed										24a. Was		4b. Were aut	opsy findings	s available
- B		E CO										perfo	rmed?	death?		Cause of
/ita	ysician: Th is certificate director, pag	Be (25. Was case referred examiner?	to medical	Lines its t							Check only o	ne)			
of	S S D	2	1 Yes 25 No 27. Manner of Death		Hospitat: 1 []		ER/Outpatie			4 🗆 Nur		ne 5 Resid		Other (Spec	fy)	
O	After After	tion		Pending	(Mon	th, Day Year)	Injury	M	c. Injury a Work?	is 2∐N		EBU. Describe i	iow injury oc	ocurred		
Division	l or Attending after death. Director: After I in by the fune	Certification:		Could not be determined	e 28e. Place	of tnjury - At h		reet, factory,	office			28f. Location (S City or Tox	Street and N vn. State)	umber or Rui	al Route Nui	mber,
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_	To the To the Complex complex	Me	29b. Signature and title	of certifier	1				License n				29d. Date si	igned (Month	, Day, Year)	
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12	1		30. Name and address		completed cau			Print)	TWO	D A	ed .	Ber	LAIR	MD	2/0/	4
	Sta Registi		31. Date filed (Month, C	ST 05	2006 32.	legistrar's Sign	ature .	park					•			

For	State of Maryland / Department of Health and I
State Registrar	Certificate of Death

			Registrar			Cer	titicate	e of L	Death	7		Reg. No.		
	- 4	7	1. Decedent's Name (First, Middle, Last)								2. Date of D			3. Time of Death
	Physicia		Deloris Naomi Bai	rd							Month Santami	Day bar 2	6, 2006	6:35 p ^M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City,	Fown or	Location		Берсеш		County of Death	7
	Examin	er												
		100	Homewood of W111 5. Social Security Number 6. Sex		do um loca	himboloul	If Under		nspo1	r 24 Hrs.	P. Data of B		Washing	
	Funeral		10	M 2X F	e (In yrs. last	Vrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D	ay, Year)		place (State or Foreign ntry)
	Director		214-42-1276		_96	115.			3.1	1	June 6	, 191	0 Penn	sylvania
	DG .		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	our or Lo	antion							10d Janida Cibat Imita
•	an and	l.	Tod. State		Toc. City, 1	OWIT OF LO	Cation							10d. Inside City Limits
	9 M	cto	Maryland Washingt	on	Hag	gerst	own							1 ☐ Yes 2 No
	or 28	- Le	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What Cou	ntry?
	h wil	Funeral Director	20009 Rosebank Way	7			2	1742				U	ISA	
	deat	Jer	11. Marital Status	2. Was Decedent I	Ever in U.S.	13. \	Vas Deced	ent of Hi	spanic O	rigin? (Spe	ecify Yes or N Rican, etc.)	0- 1	4. Race - Ameri	can Indian,
(0	fter fter	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔯 N	10					ın, Puerto	Rican, etc.)		Black, White,	
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Itams 23a or 28a-f ahow ha Mauleal Examinar must be notified at	by	3 🔯 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I□Yes 2	2⊠ No	Specify	<i>'</i> :			Specify: Wh	ite
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2	with the the	Ē	Elementary/Secondary (0-12)	College (1-4or 5		Doodo	tered	M				Mo	44001	
	iiled Hygi ther nt. I		17. Father's Name (First, Middle, Last)	•		veRTP	rered	Mui		or's Name	e (First, Middle	1	dical	
ŭ	bd o bd	Be											ourname)	
Ĕ	ould Merku	၉	Harry Dole Beck								ry Sch			
Maryland	and and is rr		19a. Informant's Name/Relationship (Typ			19b. Mailir	g Address	(Street a	and Numb	er or Rura	al Route Numb	oer, City or	Town, State, Zip	Code)
	and selth n 27 ar tr		Diane Baird/Daught	er		325 C	harle	s Ro	oad,	Mech	anicsb	ırg,	PA 1705	55
<u>s</u>	oth oth		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Nam	e of	a)		Date	20c. Loc	ation - City or To	own, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar [®] an Depertment of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-1 ahow any injury or other traumatic event, the Macical Examinational be notified at once.		1 ABurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1		en Cei		1	9/30/	2006	Насе	retown	Maryland
₫	infum.		21. Signature of Funeral Service License	e	Rest								eral Ch	
Ba	Depermination of the police of		> Sallan & C.	_										_
.A			220 Part Fotos the disease or semali	7/2	4h								rstown,	Md. 21742
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only on	e cause on each lin	ine death. I	o not ent	er the mode	ot cryini	g, such as	s cardiac o	or respiratory	arrest,		Approximate Interval Between
100	Physician		Immediate Cause (Final disease or condition	atturis.	Se- 10/0	he	woon	Lee	1 VE	Screl	and !	CPMA	2	Onset and Death
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68760,	cate phys the	n/Medical	d				_							
9 ×	ing ing e as	Me	IF FEMALE:	W 200 1 V 17	F1 005 21									
30X			23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth			Ectopic pre	gnancy				2	3d. Date of deliv	•
B	e de e	Sici	1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown	time of deat		Other (spe						Month	Day Year
P.O.	The law requires that the death sie has been signed by the etter page 2 should be detached for u	Physicia	9 Unknown	30011110411										
10	s this	by F	Part II. Other significant conditions con	tributing to death bu	ut not resultir	g in the ur	nderlying ca	ause give	n in Part	1.	23e. Did	tobacco us	e contribute to t	he cause of death?
ĕ	quire n sig uld b	P	Atrial fibrillation	- Lya	May 50	Idria	Lon	625	Live		1 🗆	Yes 25	No 3 Prot	ably 4 Unknown
<u>o</u>	r rec bee	Completed	hart Cil . la	111	/			J			24a. Wa:		045 14/	
ĕ	vician: The lav certificete has rector, page 2	g	NEAR FOILE, de	men 16					-		auto		prior to co	opsy findings available impletion of cause of
=	: Th	S									1 ☐ Yes	2. No	death? 1 ☐ Yes	2 □ No
ij	cian ertifi ector	Be	25. Was case referred to medical examiner?						26. Plac	e of Death	(Check only	оле)		
~	nysk dire	2	1 ☐ Yes 2 No H	ospital: 1 🗆 Inpatie	nt 2 ER	/Outpatien	1 3 DO	A Othe	or 4EN	ursing Ho	me 5 Res	idence 6	Other (Specia	(v)
Division of Vital Records,	Attanding Physician: or death. actor: After this certifice by the funeral director,		27. Manner of Death	28a. Date of Injus (Month, Day	ry 28	b. Time of	21	Bc. Injury Work			28d. Describe			
0	nding I th. : After e funer	atlo	Natural 5 ☐ Pending 2 ☐ Accident investigation	(North, Da)	1 (441)	Injury	м		≀: Yes 2 []No				
<u> </u>	des des cto	f C	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ury - At home	farm, str	eet. factory	office			28f. Location	(Street and	Number or Run	al Route Number,
á	f or Attancetter death ofter death Director: I in by the	Certification:	4 - Homicide determined	building, etc	c. (Specify)	,	, , , , , , ,				City or To	wn, State)		,
	To the Hospitel or Attanding Physician: The law within 24 hours efter death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier Certifying Phys	ician: To the best	of my kn	deo d		at the entire		nd clair	and direct of			
	Hos Hos Fun Fun tely	Ca	29a. Certifier Check only one) Check only	er: On the basis of	examination	and/or inv	occurred a restigation,	in my or	ie, date a pinion, de	na place, ath occurr	and due to the ed at the time	cause(s) : , date and	and manner as s place, and due t	stated. o the cause(s)
	the the	Medical	2	and manner sta	ued.									
	To Too	-	29b. Signature and title of certified				290	License	number	11			signed (Month,	
F "	,						1	17	670	10		07	7-1/2	300
	6		30. Name and address of person who co	npleted cause of de	eath (Item 23	Ba) (Type,	Print)		1				1742	
	9		W.E. Kutzera, MD	13414	Penns	m/160	ie Ne	LA	Lage	19 400	- M	رد د	1742	
. 9	Sta	te	31. Date filed (Month, Day, Year)	32, Registra	ar's Signatur	-	1 .	<u></u>	1					
0.75			OGT 0 5 20	IIIL X		10	F D.	3						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 20, 2006 5:15 p Physician Sigrid Mary Sampson Bradley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 3413 40th Avenue Colmar Manor If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F 579-20-3962 6, 1922 Washington, Director 83 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If I tem 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating the notified at 1 Yes 2 □ No Maryland Prince George's Colmar Manor Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20722 U.S.A. 3413 40th Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Foreman 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hazel Payne McDaniel Unavailable 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13065 Birch Bark Court N., Jacksonville, FL 32246 Ken D. Sampson - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 09/22/2006 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 fim Muna Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): **Examiner** Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician end s the burial-transit Exami Osteoporosis Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗓 No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' 2 🗌 No certificate 1 Yes 2X) No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 X Natural 5 Pending investigation 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 9/21/06 Xadulle M. Ul D44156) YLEXION 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alexion, MD 7500 Hanover Parkway Suite 105, Greenbelt, Maryland 20770 Rachelle 31. Date filed (Month, Day, Year) State SEP 2 5 2006 Registrar

		•	1 - For State Registrar	State of N	Maryland / Dep	ertificate of	lealth and I	Mental Hy	giene Reg. No.	006	317	30		
	Physici	an	1. Decedent's Name (First, Middle	Last)	Baten	A A . A		2. Date of De Month	Day	Year 2001	3. Time of (Death PM		
	/Medio Examir		4a. Facility Name (If not institution,	give street and number			r Location of Death	September		County of Deat				
	LAGIIII	ici	TI -	Kins Hosp		Baltimo	ce City							
	Funeral		5. Social Security Number		Age (In yrs. last birthda)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birt	Birthplace (State of Country) JASHINGTON 10d. Inside Ci XXX Yes at Country? STATES American Indian, White, etc. BLACK Ress/Industry GOVERNME 10d. Approximate Interval Bath Onset and Interva	Foreign		
	Director		577 42 3587 Usual Residence of Decedent	767	74 Yrs.			MAR. 29	, 19:	32 WAS	HINGTON	, DC		
	yland how		10a. State 10b. County		10c. City, Town or I	ocation					10d. Inside City			
	Be-fs	Director	MD PRINCE	GEORGES	ACCOKEEK							2 No		
	with the		10e. Street and Number			10f. Zip Code			-	en of What Co				
	ns 23	Funerai	2101 CARL COURT 11. Marital Status	12. Was Decede	nt Ever in U.S. 13	. Was Decedent of H	lispanic Origin? (S	pecify Yes or No						
9	or iten	Fun	1 ☐ Never Married 2XXMarri	Armed Force	es?	If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)		Black, White				
21215-0036	d within 72 hours after death with the Maryland Jiene. I then "natural", or Items 23a or 28e-f show The Medical Esaminet must be redified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date		1 ☐ Yes XX No	Specify:							
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	othe /ent,	BeC	17. Father's Name (First, Middle, I	ast)	,		18. Mother's Nan	ne (First, Middle						
<u>X</u>		70	JOSHUA QUARLES				SUSIE '				N			
Maryland	S S S S S S S S S S S S S S S S S S S		19a. Informant's Name/Relationsh TAMMY HOLDER /			ling Address (Street OUEEN ST		ural Route Number, City or Town, State, Zip Code) WASHINGTON, DC 20002						
	s 1 and 2 f Health Item 27 I		20a. Method of Disposition	DAUGHTER	20b. Place of Disp	position (Name of		Date						
MO	Pages nent of int: if it iry or o		1XXBurial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (St		110	ematory or other place COLN CEME		26/2006	BRI	ENTWOOD	, MD			
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any injury or ot		21. Signature of Funeral Service I			22 MARSHALL								
8	89888		1.7.11	lousell			TLAND ROA							
П			23a. Part1. Inter the disease, or shock, or heart failure. List	complications that cause on each	sed the death. Do not en h line.	nter the mode of dyir	ng, such as cardiad	or respiratory a						
	Enysician /Medical	e i	Immediate Cause (Final disease or condition resulting in death)		nary Arton	al Hypo	rtension				15	5		
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		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence of):	ar rain	JI C				3 year	2		
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. Renal	Failure						3 days			
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Box 6	death certificat e attending phy of for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor					2:	3d. Date of del	ivery			
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Ś	ires that signed b	by	Part II. Other significant condition	ns contributing to death	h but not resulting in the	underlying cause giv	ren in Part I.	23e. Did t		^				
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Vital		e Co	25. Was case referred to medical				26. Place of Dea	1 Yes	200 No	1 ☐ Yes	2□ No			
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n of	ding Ph h. After th funeral		27. Manner of Death T⊠Natural 5 ☐ Pending	28a. Date of I (Month,	njury 28b. Time Day Year) Injury	Wor	k?	28d. Describe	how injury	occurred				
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Σį	Title L	ertif	4 Homicide determine	ned 286. Place of	Injury - At home, farm, s , etc. (Specify)	treet, factory, office		City or To		Number of At	irai Houle Numi	er,		
_	spite ours nerel filled		29a. Certifier 12 Certifyin	g Physician: To the be	est of my knowledge, dea	ath occurred at the tir	me, date and place	e, and due to the	cause(s) a	and manner as	stated.			
	To the Hos within 24 h To the Fur completely	edical	(Check ohly 2 Medicel i	Examiner: On the basis and manner	s of examination and/or i	investigation, in my o	ppinion, death occu	irred at the time,	date and	place, and due	to the cause(s)			
	To the within 2. To the complet	Σ	29b. Signature and title of certifier	1 -1		29c. Licens	se number		29d. Date	signed (Monta	h, Day, Year)			
^	2		Mausha	JOBIL, MI)	KES	-000		Septe	mber 18	,2006			
L	(9)		30. Name and address of person	who completed cause of	of death (Item 23a) (Type	e, Print)	h 10/01/20 C1	neal Rall	ing.	Manland	7126	7		
1	Sta	ite	Marisha (Month, Day, Year)	32. Regi	istrar's Signature	W =	n work st	rece, valt	irione,	rungione	4178			
	Regist		SEP 2 2 204	16 Bleen	, it goes	a)								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Month Year **Physician** 20, Sept. 2:35 a Teresa Block /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 21 F 93 Illinois 318-03-7919 7/15/1913 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1⊠Yes 2 No Prince George's Cheverly Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 6103 Kilmer Street 20785 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No White δ Specify: 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Law Office . Pages 1 and 2 should be filed w tment of Health and Mental Hygien tant: If item 27 is marked other to jury or other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary O'Conner David Bohan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Wickersty - Daughter 6103 Kilmer Street, Cheverly, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 N Removal from State All Saints Cemetery 9/23/2006 Des Plaines, IL 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Ave., Hyattsville, MD 20781 March 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CENEBROVA>CUL /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 ☐ Probably 4 ØUnknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 ☐ Yes 2 ☐ No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient ို 1 Tes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation М 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 24 within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP 2 2 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Critificate of De Registrar		Reg	g No. 200	5 3173		
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Patrick P. Buck		Date of Death Month September	Day Year 27, 2006	3. Time of Death 2015 hrs		
ant one,		4a. Facility Name (if not institution, give street and number) 4b. Ci	ty, Town, or Location of Dea		4c. County of Death			
- Formula			ney Jnder 1 Year If Under 24H	Irs 8 Date of Birth	Montgomery (MM/DD/YYYY) 9. Birt	hplace (State or		
Funeral Director				April	Foreig			
any	1	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits		
vfaryland 28a-f show any d at once.	ō	MD Montgomery Damas		···-		1 X Yes 2 No		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 25850 Woodfield Road	Zip Code 20872		g. Citizen of What Cour United Stat	•		
r death with or referms 2 or items 2	Funeral	1 Never Married 2 Married Armed Forces? If Yes, sp. 1 Yes 2 No.	pedent of Hispanic Origin? (pecify Cuban, Mexican, Puer		14. Race - Ameri White, etc.			
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M 2 alth		Shirley Buck / Wife 25850 W	oodfield Road	l, Damasc	us, MD 2087			
Baltimore, MD 2 permit Pages I and 2 shou Department of Health and 8 Important: If item 27 is r injury or other traumartic		1 X Burial 2 Cremation 3 Removal from State crematory or other plants of the Specify All Souls Ce	,	tober 2	Germantow	·		
Balt permit Depart Import injury	9	TRACY A Sture Dee	r Park Drive.	Gaither	eral Home, sburg, MD 2	.0877		
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mofailure. List only one cause on each line.			st, shock, or heart	Approximate Interval Between Onset and Death		
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uted nd ransit		events resulting in death) Last Due to (or as a consequence of).						
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on of ending Pl ath. or: After the funera	S and A seidest S Pending (Month, Day, Year) Pending Find 9/27/2006 Find 7:50 pm 1 Yes 2 No unk							
Division of ' pital or Attending Pli unts after death. eral Director: After t	Certification:	3 Suicide 6 Y Could not be 28e. Place of Injury - At home, farm, street, fac		28f. Location (S	treet and Number or Ru ate) 25850 Wood	ral Route Number, City		
Di Hospital 24 hours a Funeral	Cert	4 Homicide A determined (Specify) House 29a. Certifier (Control of the best of pulses) death accorded to the control of the best of pulses and the best of pul		Lanascus	, MD			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ledical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated						
->-0	Me	29b Signature and title of certifier	29c. License number O.C.M.E.		29d Date signed (Mo			
à		Yanate yuthalf, MIS	U.C.IVI.E.		September 28, 2			
3		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Pe	enn Street, Baltimore	, MD 21201				
S Regis	tate trar	31. Date filed (Month CT Yet) 3 2006 32. Redistrar's Signature	Z.					
1.0915	-14-1							

		-	For State Registrar	State of M	aryland		rtment of H tificate of L		nd Mental	Hygiene Reg. No	UUD	31733
b	Physici		1. Decedent's Name (First, Middle, Last Marie Dorot		an				2. Date Month Septe	Da Da	y Year 24, 200	3. Time of Death 10:35 AM
	/Medic Examín	_	4a. Facility Name (If not institution, give Egle Nursing Ho		r)		4b. City, Town, or Lonacol		Death		County of Dea	
***	Funeral Director		5. Social Security Number 6. Se 215–16–4436	x 7. A	Age (In yrs. lasi 84	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Mont	of Birth h, Day, Year)	C	thplace (State or Foreign ountry) aryland
	how		Usual Residence of Decedent 10a. State 10b. County		10c. City, T							10d. Inside City Limits 1 ☐ Yes ※∑No
	the Ma 28a-f s	ecto	MD. Allega	ny	W	ester	nport			10g. Ci	tizen of What C	<u></u>
	th with	al DI	25801 Shady Lane				2150	62		Unit	ted Sta	tes
980	be filed within 72 hours after death with the Maryland nat Hyglene. ed other then "naturel", or Iteme 23a or 28a-f show event, the Medical Exeminer must be mailified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed Wybivorced	12. Was Deceder Armed Force 1 Tyes 2 If If Yes, Give Year or Dates	s? No	11	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 X No	ispanic Origi n, Mexican, Specify:	n? (Specify Yes Puerto Rican, etc	or No-	14. Race - Am Black, Whi Specify: W	ite, etc.
Maryland 21215-0036	ithin 72 hor ie. ien "natur	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-40		(Give life. L	ent's Usual Occupa	during most (of working		ind of Business	
d 21	Hygi Hygi ther nt, I		unknown 17. Father's Name (First, Middle, Last)			Al	uto Build		s Name (First, N	iddle, Maider	n Sumame)	
ylan	should be and Mental smarked o	To Be	William Frost		_				Elizabet			
Man		j	19a. Informant's Name/Relationship (T) Dale Beeman/ son	ype, Print)			g Address (Street and Dogwood)				_	_
Baltimore,	Pages 1 and 2 nent of Health, int; if Item 27 iny or other tre		20a. Method of Disposition 1 Burial Experimentation 3 4 Donation 5 Other (Specify,		te cem	netery, cren	sition (Name of natory or other place nd Cremat		Date 09/25/ 2006		ocation - City o berland	r Town, State Maryland
Balti	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21. Signature of Funeral Service Licens	ne b	20		. Name and Address 11 Church		Boal Fu			nd 21562
8760,	Physician /Medical Examiner physician and physician and the prival-transit	dical Examiner	23a. Part1. Enter the disease, or companions, or heart failure. List only of disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consequent	nce of):	umor	4.				Interval Between Onset and Death
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown		2 Fetal di at time of dea	eath 3	Ectopic pregnancy Other (specify)	· =			23d. Date of d Month	elivery Day Year
<u>α</u>	juires that n signed b	þ	Part II. Other significant conditions of Severe	Dem en	tia	ing in the u	nderlying cause giv Ane m		23e	Did tobacco		to the cause of death? Probably 4 Unknown
Records,	The law require ate has been signage 2 should t	Completed							24a	Was an autopsy performed? Yes 200 N	prior to death?	autopsy findings available completion of cause of second No.
Vital	sicien: The certificate hi	Be	25. Was case referred to medical examiner?	Hospital:	atient 2 ☐ EF	D/Outseties	• aCT BOA Oth		of Death (Check		6 DOthor (Sa	200(64)
of	Phy: this	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of I		8b. Time of Injury	28c. Injur Wor	y at		cribe how inju		юспу)
Division	To the Hospitel or Attending is within 24 hours after death. To the Funerel Director; After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	200. Place 01	Injury - At hom etc. (Specify)	ie, farm, str	eet, factory, office			tion (Street a or Town, Sta		Rural Route Number,
	Hospit 24 hour Funer tely fills	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be niner: On the basi and manner	s of examination	ledge, deat on and/or in	n occurred at the till vestigation, in my o	me, date and opinion, deat	d place, and due h occurred at the	to the cause(time, date ar	s) and manner and place, and d	as stated. ue to the cause(s)
	To the within ?	Med	29b. Signature and title of certifier	SCSO	wdh	nKú	29c. Licens	number	64	29d. D	ate signed (Mo	nth, Day, Year) 5/ 2006
•			30. Name and address of person who of Dr. S L Sandhir,				Print)	warti	land 21	532		
		ate	31. Date filed (Month, Day, Year)		istatos Signatu		oscourg,	Mar A-				
	Regist	rar	ye. 4	a range	A STATE OF	A POR	23000 D					

		Please T	ype or Print						•	_	ible.	
		For State	State of Mar	yland	•		of Health of Death			00	0.6	01701
		Registrar 1. Decedent's Name (First, Middle, Last)			Cer	uncate	oi Deali		2. Date of Dea	eg. Noc	Ub.	3. Time of Death
Physicia			HURLEY	BRIT	TINGH	IAM			Sept.	23,2	Year COO G	2:20 PM
/Medica Examine		4a. Facility Name (If not institution, give s	street and number)			4b. City, Tov	vn, or Location	of Death		4c. Count	y of Death	
		Salisburykehal		In yrs Pas	Ctr	Sa.	lisbe	or 24 Hrs.	8. Date of Birth		com	place (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 1	M 2 F 85	in yrs. las	Yrs.		ays Hours	Min.	Month, Day	, Year)	Cou	place (<i>State of Poreig</i> n n <i>try)</i> VA
pug 💃		Usual Residence of Decedent 10a, State 10b, County	1	IOc. City.	Town or Loc	cation						10d. Inside City Limits
Maryla febor	ō	MD WORCESTE		•	MOKE							1 ☐ Yes 2 ☐ No
h the	Director	10e. Street and Number	210	1000	110112	10f. Zip Co	de		1	0g. Citizen of	What Cou	ntry?
23a c	la l	1018 LYNN HAVEN				2185				USA		
lter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 Yes 2 No		13. V	Vas Decedent Yes, specify	t of Hispanic O Cuban, Mexica	rigin? (Spec an, Puerto F	cify Yes or No- Rican, etc.)		ice - Ameri ack, White	can Indian, , etc.
urs at	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 25	No Specify	y:		Spec	ity: W	HITE
72 ho	eted	15. Decedent's Educ (Specify only highest grade			(Give	ent's Usual O kind of work o	lone during mo	ost of workin	g	16b. Kind of I	Business/Ir	ndustry
within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			OO NOT use r MEMAKE				DOI	MESTI	С
e filed al Hyg other vent,	BeC	17. Father's Name (First, Middle, Last)					18. Moti	her's Name	(First, Middle,	Maiden Suma	me)	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene and Mental Hygiene is marked other than "natural", or liema 23a or 28a-f show raumatic event, the Medical Examinar must be notified at	2	HENRY S. HURLEY,						ILLIE				
s 1 and 2 should be filed within 72 hours after death with the Marylan felleath and Marylan Bland and 1 should be filed within 72 hours after death with the Marylan fem 21 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, it we Modical Examinational be notified at		19a. Informant's Name/Relationship (Type RICHARD S. BRITT	· · · · · ·			-			Route Number	-		
is 1 and of Health Item 27 other tr		20a. Method of Disposition		20b. Plac	e of Dispos	sition (Name o	of r place)	Da	ate	20c. Location	- City or T	own, State
Pages ment of the ant: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		•	ETERY		9/26/		POCOMOI		
permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other trai		21. Signature Puneral Service License	-	THODN			ddress of Faci	•	2418: 1. PARK	3 CHADI		
		23a. Part 1. Enter the disease, or compli	cations that caused th	ne death.							VA 23	Approximate
Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.		- 0. 0	2	Rec.	cila				Interval Between Opset and Death
/Medical Examiner		resulting in death)	Due to (or as a	consequer	nce of):				D .			1
ZAGIIIIIO	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequer	nge of):	and	ay.		Derec		- 5	427-
ecuted and -transit	camin	cause. Enter Underlying Cause (Disease or injury that initiated events	·	/	/		/					
	<u> </u>	resulting in death) Last	Due to (or as a	conseque	nce of):							
ficate be ex physician s the burial	edicai		i									
	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of 1 Live birth 2			Ectopic pregr				23d. D	ate of deliv	ery
e death	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at tir			Other (speci				N	lonth	Day Year
res that the de signed by the a l be detached f		Part II. Dther significant conditions cor	ntributing to death but	not resulti	ing in the ur	nderlying caus	se given in Parl	t I.	23e. Did to	bacco use co	ntribute to	the cause of death?
quires n sign	ed by								1 🗆 Y	es 2 Mo	3 □ Pro	bably 4 Unknown
aw requir as been si 2 should	piete								24a. Was a	ın 24b	. Were aut	opsy findings available ompletion of cause of
	Completed								perfor	med? 2 No	death?	
sician: The law s certificate has t	Be	25. Was case referred to medical examiner?	lospital:	-0			Othor	/	(Check only or			
Physe ar this eral different differe	ا: ا	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day)		VOutpatien 8b. Time of		Injury at Work?		ne 5 Reside			<i>fy)</i>
anding F sath. or: After he funer	atio	1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(MOIIII, Day	rear)	Injury	М	1 Yes 2	□No				
or Att after de Directe in by t	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At hom (Specify)	e, farm, stre	et, factory, o	ffice	2	8f. Location (S City or Tow		ber or Rui	al Route Number,
re re re re re re re re re re re re re r	edical Ce	(Check only 2 Medical Exami	sician: To the best of ner: On the basis of e	xaminatio								
ro ths vithin 2 or the	Med	29b. Signature and title of certifier	and manner state	ru.		29c. L	icense number	r	2	9d. Date sign	ed (Month	Day, Year)
F > F O		10000	hen			0	729	34	9 /	7/25	706	
		30. Name and address of person who co	A	ath (Item 2	3a) (Type,	Print)	. 1	d	took !	/	7	
Stat		31. Date filed (Month, Day, Year)	32. Registrar		200	440	UFIVE	Li Da	disbu	J'm	W 5	11804
Registra	_	SEP 2 9		was	K	Charle	,			~		

Registrar DHMH 17 Rev 1/2001

			for State Registrar			of Mary	rland /	•	rtmer tificat				lental H	Reg. I	2 U	06	31735
	Physici /Medic		1. Decedent's Name BE	e (First, Middle, L TTY	.ast)	BOND	•						2. Date of D Month Septem		19	Year 2006	3. Time of Death 1:25 P M
	Examin		4a. Facility Name (I	f not institution, g CK MEMOF						Town, or		n of Death				y of Death ERICK	
	Funeral Director		5. Social Security N 169–46–60	umber 6.	Sex 1 ☐ M 2 ☐ XF		yrs. last b.	irthday) Yrs.		r 1 Year		er 24 Hrs. Min.	8. Date of B (Month, f Oct • I	1			olace (State or Foreign orry) Sylvania
	and		Usual Residence of 10a. State	Decedent 10b. County		10	c. City, Tov	vn or Loc	cation							1	0d. Inside City Limits
	Mary!	tor	MD	Frederi	ck	F	reder	ick									1X Yes 2 ☐ No
	after death with the Marylan or items 23e or 28e-f show infree must be notified at	ai Director	10e. Street and Nur 751-B Hea		lge Driv	e			10f. Zij	702				10g. US		What Cour	ntry?
030		by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ied 2□ Married 4 X Divorced	12. Was Dec Armed F 1 Tes If Yes, G Year or	orces? 2 [Z]No	r in U.S.	1	Vas Dece Yes, spe		lispanic (an, Mexic Specia		ecify Yes or N Rican, etc.)	lo-	Bla	ce - Americ ick, White, ^{fy:} Whit	etc.
9500-6121	within ene. then	Completed	(Spec	15. Decedent's ify only highest g	rade completed) (1-4or 5+)		Deced (Give life. L		al Occup ork done o ise retired	ation during m	ost of work	ing		Kind of E	Business/Ind	dustry
landz	d be filed ental Hygi ced other c event.	To Be Co	17. Father's Name Joseph Ha				1						e (First, Midd. hnson	le, Maid	en Suma	me)	
Maryland	s 1 and 2 should I Health and Men Item 27 is marke other treumatic	-	19a. Informant's Na JoAnn Coa						_				al Route Num				Code)
	m O .		20a. Method of Disp	position XCremation 3	☐Removal from	Jiale	20b. Place cemete	of Dispos ery, crem	sition (Na natory or	me of other plac	ce)		Date	20c.	Location	- City or To	
Baitimore,	permit. Page Department of Importent: If eny injury or once.		4 Donation 21. Signature of Fu	5 Other (Specineral Service Lig			Chesa	ර ිරි	Name a	Hôme	ss e Fa	Matic	n Serv	ice	P.0		784
	Physician	0 1	23a. Part1. Enter ti shock, or hea Immediate Cause disease or conditio	(Final	mplications that ly one cause on				er the mo	de of dyin	ng, such	as cardiac	or respiratory		Larks	sville	Approximate Interval Between Onset and Death
5876U,	Medical Examiner b physician and physician and physician is the burial-transit	edical Examiner	resulting in death) Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) if		b	epas of as a co	onsequence	Ker e of):	ral	Sh	iut	di	ren				
P.O. Box 6	death certi e attending ed for use a	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 21 9 ☐ Unknown	months? ☑No		birth 2 ☐ nant at tim	Fetal deat		Ectopic p Other (s		/					ate of deliver	ery Day Year
	as the	Š	Part II. Other signif			death but n			derlying cout			rt I.					he cause of death?
Vital Records,	o 6	Completed											24a. Wa aul per 1 Yes	opsy formed	~	Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available impletion of cause of
/Ital	siclan: Th certificate irector, pag	Be	25. Was case reter examiner?	/	Hearital								th (Check only	/ on <i>e)</i>			
	ng Phys fter this ineral di	ion: To	1 ☐ Yes 2 ☑ 27. Manner of Deat 1 ☑ Natural		28a. Date (Mo	Inpatient of Injury oth, Day Ye	2 ER/C 28b.	Time of Injury		28c. Injur Wor			ome 5 Re 28d. Describ				(y)
Division of	2	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not determine	be 28e. Place	e of Injury ding, etc. (S	- At home, s	farm, stre					28f. Location City or T			ber or Rura	al Route Number,
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	edicai	29a. Certifier (Check only one)	1 Medical Ex	Physician: Tult aminer: On the and ma	basis of ex nner stated	amination a	je daalh ind/or inv	estigation	at the tir	na data pinion, d	and place eath occur	and due to the red at the time	e, date :	and place	, and due to	o the cause(s)
)	To t To t	Σ	29b. Signature and	title of certifier	w 1	mD.	,			c. Licens		ır			_		Day, Year)
ص	> -		30. Name and addr						Print)	5463				sel	Lemb	er 20	2006
	Sta	10	Syed Haq 31. Date filed (Mon			nt C1 Distrar's		Ave.	Fre	deri	ck,	MD 21	.701				
	Registi			SFP 2 5	1	Late De		A	- 40								

Division of Vital Records, P.O. Box 68760,

State Registrar 32. Register's Signature Blown & Sports

RAM K. RASTOGI, MD, 7575 RITCHIE HWY., GLEN BURNIE, MD 21061

NS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

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9/22/06

Provided Target Barry See See See See See See See See See S				1 - For Registrar AMEND#22penF		Maryland / Department	artment of F		Mental Hygie	2000	31737
Trop and Bark Examined Females Femal						2.17.200			2. Date of Death		32Time of Death
Security Processor Social Security Numbers Sec				Irmgard Birk							2.45рш
Second Second Variable Second Second Variable Second Second Variable Second				4a. Facility Name (If not institution, gr	ive street and numb	oer)	4b. City, Town, or	r Location of Death		4c. County of Deatl	1
The state of the s											-
Discourage Control C	П				Sex 1 M 2 X F 7.	95 Yrs.	Months Days		(Month, Day, Ye	ear) Co	untry)
Total Park Name (First, Models, Last) Meler Goldschmidt Selma (Michael Makina Dimana) Selma				Usual Residence of Decedent					1107. 23	1710	
Total Park Name (First, Models, Last) Meler Goldschmidt Selma (Michael Makina Dimana) Selma		rylan	_	10a. State 10b. County		10c. City, Town or L	ocation				
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Total Park Name (First, Models, Last) Meler Goldschmidt Selma (Michael Makina Dimana) Selma	30	rs after de l', or item	oy Fune	1 Never Married 2 Married	Armed Force 1 ☐ Yes 2 If Yes, Give	es? X No	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, White	White
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Sequentially list conditions, cause. Eneral Underlying Cause Disease or injury that strainfall events that strainf		Physician		Immediate Cause (Final			sease				Onset and Death
Sequentially list conditions as a consequence of light of the property of the				resulting in death)	Due to (or	as a consequence of):					
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FFEMALE 23d. Date of delivery Month Day Year		t to sit	m L	cause. Enter Underlying Cause (Disease or injury							
1 Ves 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy prior to completion of cause of death? 1 Ves 2 No 3 Probably 4 Unknown 25. Was case referred to medical systems of the prior to completion of cause of death? 1 Ves 2 No 3 Probably 4 Unknown 25. Was case referred to medical systems of the prior to completion of cause of death? 1 Ves 2 No 3 Probably 4 Unknown 26. Place of Death (Check only and prior to completion of cause of death?) 27. Manner of Death Part II. Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 1 Ves 2 No 2 No 2 No 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only and place, and due to the cause(s) and manner as stated. (Check only and place, and due to the cause(s) and manner as stated. (Check only and place, and due to the cause(s) and manner stated. (Check only and place, and due to the cause(s) and manner stated. (Check only and place, and due to the cause(s) and manner stated. (Check only and place, and due to the cause(s) and manner stated. (Check only and place, and due to the cause(s) and manner stated. (Check only and place, and due to the cause(s) and manner stated. (Check only and place, and due to the cause(s) and manner stated. (Check only and place, and due to the cause(s) and manner stated. (Check only and place, and due to the cause(s) and manner stated. (Check only and place, and due to the cause(s) and manner stated. (Check only and place, and due to the cause(s) and manner stated. (Check only and place, and due to the cause(s) and man	<u>,</u>	exection and and rial-tra		resulting in death) Last		as a consequence of):					
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1 Watural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D24245 9/18/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Diamond MD 10801 Lockwood Drive #200 SIlver Spring MD 20901		9 v =	0		Hospital:	patient 2 ER/Outpatie	nt 3□ DOA Oth	ner: 4 🗌 Nursing H	ome 5 💢 Residenc	e 6 Other (Spec	cify)
Solution of the specific property of the speci		Ing Pt		1 ◯Natural 5 ☐ Pending	(Month,	Injury 28b. Time of Injury			28d. Describe how	injury occurred	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Diamond MD 10801 Lockwood Drive #200 SIlver Spring MD 20901		a Hospita 24 hours Funeral etely filled		(Check only 2 Medical Ex	aminer: On the bas	is of examination and/or in	th occurred at the tire	me, date and place ppinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Diamond MD 10801 Lockwood Drive #200 SIlver Spring MD 20901				Mark	Comones	/ MD.	D2424	45	9,	/18/2006	
State Registrar SEP 2 1 2006 32 Registrar's Signature								Ilver Spr	ing MD 209	901	
					32 Rec	gistrar's Signature	weed				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Annapolis

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Reg. No.

16,

Day

2006

4c. County of Death

United States

16b. Kind of Business/Industry

Own Home

Maryland

20c. Location - City or Town, State

Alexandria, Virginia

23d. Date of delivery

Sept. 20, 2006

116 Defense Hwy. Suite 400 Annapolis, MD 21401

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

14. Race - American Indian, Black, White, etc.

Specify: White

Anne Arundel

10:07 p.M

Birthplace (State or Foreign Country)

10d Inside City Limits

Approximate Interval Between Onset and Death

5 Days

5 Days

1 ☐ Yes 2 ☑ No

New York

2. Date of Death

Sept.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REEDHAN

egislrar's Signature

1. Decedent's Name (First, Middle, Last)

Schmitt

1□ M 2□ F

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

Bungay

93

7. Age (In yrs. last birthday)

Helen

5. Social Security Number

087-07-0723

Physician

/Medical

Examiner

Funeral

Director

DHMH 17 Rev 1/200

Registrar

MICHAS

31. Date filed (Mont)

2245

Baltimore, Maryland 21215-0036

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Zenab Bakhashuwein 10:10p M M.A. 9-16-06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Springs If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8-21-1944 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 N 62 577-06-9460 Director Rwanda Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other then "natural, or iteme 23a or 28a-f ehow 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or then "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at Md. Montgomery Rockville 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 738 Ivy League Lane Belgium Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 27 Married by 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) IMF Adminstrative Director permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other ti any injury or other traumatic event. The once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mohamed Abdallah Salama Maqid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacques Botteman- Husband 738 Ivy League La, Rockville, Md. 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Buriai 2 ☐ Cremation 3 ☐ Removal from State George Wash Cemet, 9-18-06 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Universal II Mortuary Inc. Ru 411Kennedy St, N.W., Wash, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 1 WK Immediate Cause (Final disease or condition resulting in death) Hepatorenal Syndrome Physician /Medical Due to (or as a consequence of): Examiner Hepatic failure from Cancer 2mos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and the burial-transit Metastitic breast Cancer 5yrs Due to (or as a consequence of): Physician/Medical as nse : IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 \(\sum \) Yes \(2 \) \(\sum \) No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 ☐ Unknown Completed 1 ☐ Yes 2 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1□ Yes 2X No 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 XInpatient 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21X No 2 ER/Outpatient 3 DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident Director: in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funerel Di completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35996 9-17-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda M. Burrell, MD 2730 University Blvd #400, Wheaton, Maryland 20906 31. Date filed (Month, Day, Year) SEP 2 1 32 Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death

Registrar

			For State Registrar	State of Ma	aryland		artment tificate				Reg	ene 3. N2 0 0 6	3	1740
	Physici /Medic	_	1. Decedent's Name (First, Middle, La Mary Madeline C							2. Date Monti Sept	h	Day 2006	ar l	7:05 P M
7	Examir		4a. Facility Name (If not institution, giv				4b. City, T	own, or i	Location of Dea	th		4c. County of D	eath	
			11430 Renner Ro		- // /		Keyr If Under 1		If Under 24 Hrs	9 Data	of Diah	Frederi		(State or Familia
	Funeral Director		5. Social Security Number 6. S 217–32–5960	¹ M 2 M F 73		ast birthday) Yrs.		Days	Hours Min		h, Day , 1	(ear) 0.1933 Ma	Country)	(State or Foreign nd
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. lr	nside City Limits
	Maryl -1 sho	to	MD Frederic	k	Kevr	nar							12	XXYes 2□No
	or 28a	irec	10e. Street and Number		ricyi	IICL	10f. Zip (Code			100	g. Citizen of What	Country?	
	ath wi	rai	11430 Renner Roa	T				757				JS		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23e or 28a-f show mith injury or other traumatic event, the Madical Examinant he indifficult and once.	by Funeral Director	11. Marital Status 1 ☐ Never Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates:		i	Was Decede f Yes, specif 1 ☐ Yes 2		panic Origin? (S , Mexican, Puer Specify:	Specify Yes to Rican, etc	or No- c.)	14 Race - A Black, W Specify: 7		dian,
5-0036	2 hour	ted t	15. Decedent's E	ducation	1	16a. Deced	lent's Usual	Occupat	tion		16	6b. Kind of Busine		у
21215	thin 7: e. an "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	5+)	(Give life. I	kind of work DO NOT use	done du retired)	uring most of wo	nrking				
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Maryland	d be fi	To Be	17. Father's Name (First, Middle, Last, Kirby Gilbert Pr						Elizab			aiden Sumame) N		
ary	should and Men s marke umatic	ř	19a. Informant's Name/Relationship (19b. Mailir	g Address (Street ar				City or Town, State	e, Zip Code	9)
	and 2		Donna Rinker, Dau	ghter								s Ferry		
Baltimore,	ges 1 t of H if iten or oth		20a. Method of Disposition 1 2 Burial 2 Cremation 3	Removal from State	- 1	ace of Dispo				Date		Oc. Location - City		
Ë	it. Pa irtmen irtent: njury		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		Edge	e Hill						narles To	own,	WV
Ba	permit. Departr Importe any inju		NO 1 AI	5		T	Jeffe	rson	Chapel	Funer	al H	Home		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death	. Do not ent	er the mode	of dying	, such as cardia	c or respirat	ory arres	it,	Inter	roximate rval Between
	Physician		Immediate Cause (Final disease or condition	a Liv	es	fai	JUR.	2					Ons	et and Death
	/Medical Examiner		resulting in death)	Due to (or as	1		_							
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as		ence of):	S	^	use of con-	i in the second				
	cuted	Examin	that initiated events	· No	nal	coh	ohe	Fa-	Hy.L.	ve-D	Se	ase		
8760,	certificate be executed rding physician and use as the burial-transit	al Ex	resulting in death) Last	Due to (or as	a consequ	ence of):			,					
687	ficate physics the l	edica		_ d										
Вох	eath certific attending p	M/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	onancy				23d. Date of	,	
.O. B	requires that the death een signed by the atter hould be detached for u	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ███ 9 ☐ Unknown	4□Pregnant at 9□Unknown			Other (spe					Month	Day	Year
Ω.	uires that the de signed by the a Id be detached f	y Ph	Part II. Other significant conditions of	contributing to death b	ut not resu	Iting in the u	nderlying car	use giver	n in Part I.	23e.	Did toba	cco use contribute	to the cau	use of death?
rds	w requires been sign should be	ed by									1 🗆 Yes	2 ₺ 10 3 🗆	Probably	4 Unknown
ဓင္ပဝ	- D 0	Completed									Was an autopsy	24b. Were	autopsy fi to complet	indings available ion of cause of
<u>=</u>	: The law icate has									10	performe /es 25	ad? deatr	i? 'es 2□	
Vit.	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	005			Other	26. Place of De		/			
o	g Physer this erthis	n: To	27. Manner of Death	1 ☐ Inpatie 28a. Date of Inju (Month, Da		ER/Outpatien 28b. Time of Injury		c. Injury	at □ Nursing i	7		ce 6 □Other (S rinjury occurred	ресіту)	
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Division of Vital Records,	el or Att	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ury - At hor c. <i>(Specify</i>)	me, farm, str	eet, factory,	office			ion (Stre or Town,	et and Number or State)	Rural Rou	ite Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (nysicien: To the best niner: On the basis of and manner sta	f examinati									
	To th withir To th comp	ž	29b. Signature and title of certifier	101/	11	0.0		License				d. Date signed (Mo	nth, Day,	Year)
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	2		30. Name and address of person who	completed cause of d	leath (Item	23a) (Type,	Print)	n na	054 25 Joh	V 500 0	D- 1	FILO Fra	Percel	C MO
	Sta	te	31. Date filed (Month, Day, Year)	106 32 Registr	ar's Signat	ufe	rect s	W IV II	5) J 64	II NO N C	7	, 118	4.0	100
	Registi	ar	001002	grad West	and the	1	Mary Charles							

			1 - State Registrar	State of Ma	-	•	ment of H		d Mental Hy	giene	006	31741
1	* * * A		Decedent's Name (First, Middle, Last)						2. Date of D	eath		3. Time of Death
	Physic /Medi		LAVENIA	U.	CHAR	RLES			Month SEPTE	MBER	16 2006	11:48P M
	Exami		4a. Facility Name (If not institution, give s			4b	. City, Town, or		eath	4c. (County of Death	
			THE JOSEPH RITCH		a (la con la ce biet	h-4) If	BALT Under 1 Year	IMORE	Hrs 0 Date of Bi	-46-	O Dist	alana (Chata as Familia
	Funeral Director		205-34-5268	/. Ag	e (In yrs. last birti		onths Days		Ain. (Month, D	ay, Year)	Cou	place (State or Foreign intry) NSYLVANIA
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location	on					10d. Inside City Limits
	Mary ind	ğ	MD PRINCE G	EORGE'S	UF	PPER	MARLBOR	0				1X Yes 2 No
	h the	Director	10e. Street and Number				Of. Zip Code			10g. Citiz	en of What Cou	intry?
	deeth with the Maryland ms 23s or 28s-f show fitted be notified at	la D	110 CHARTSEY STREE	T			2077	4			U.S.A.	
		Funeral	The transfer of the total of	12. Was Decedent Armed Forces?		13. Was	Decedent of Hi s, specify Cuba	ispanic Origin' n, Mexican, Pi	(Specify Yes or Nuerto Rican, etc.)	0- 1	4. Race - Amer Black, White	ican Indian, , etc.
<i>2</i> 000	within 72 hours after deeth with the Marylan ane. then "naturel", or Itama 23a or 28a-f show in Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	No	1 🗆	Yes 2ÃΩNo	Specify:			Specify:	BLACK
Ø 1	be filed within 72 hc tal Hygiene. d other then "nature event, the Medical	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a.	Decedent' (Give kind	s Usual Occupa of work done of NOT use retired	ation during most of	working	16b. Kin	d of Business/I	ndustry
10	within ane.	m	Elementary/Secondary (0-12)	College (1-4or 5	5+))		CC	VERNMEN	ਹ ਾ
10 3	D D D	ပိ	12th 17. Father's Name (First, Middle, Last)			SECK	ETARY	18. Mother's	Name (First, Middle			N T
77		To Be	GARLAND UZZLE					CLAIR	MAE MITO	HELL		
9	od 2 should lith and Mer 27 le marke treumatic		19a. Informant's Name/Relationship (Type NATHANIAL CHARLE						r Rural Route Numb UPPER MA			CAND 20794
6	S 1 ar f Hea f Hea other		20a. Method of Disposition		20b. Place of	Dispositio	n (Name of ry or other place	a) I	Date	20c. Loc	ation - City or T	own, State
25	mit. Pages 1a met. Pages 1a pertment of Her portant: if item y injury or oths		1 ⊠ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			ANS CEN	1	22/2006	CHE	TENHAM	,MARYLAND
4	partitioner, modernite Pages 1 and 2 Department of Health a Important: If Item 27 1e any Injury or other treuging.		21. Signature of Funeral Service License	e / //	1		me and Addres		J. B. JE	NKINS	FUNERA	L HOME
1	705 29		K.D.14-	-hall					DAD LANDO		MARYLAN	
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	e cause on each lin	I the death. Do n	ot enter th	e mode of dying	g, such as car	diac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final / disease or condition resulting in death)		CALL	29	10%	10				W/K3
	Examiner			Due to (or as	a consequence o							/
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter UT derlying Cause (Disease or injury	Due to (or as	a consequence o	of):						
(1)	cate be executed by sician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
2760	De exectan a	Ä	resulting in death) cast	Due to (or as	a consequence o	of):						
7	physi	dicai	, d									
hai	death certific	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		opic pregnancy ner (specify)		•	2:	3d. Date of deliv	rery Day Year
\mathcal{O}	by the clacked	hys	9 Unknown	9□ Unknown								
_ 0	gned geded	d by P	Part II. Dther significant conditions con	tributing to death be	ut not resulting in	the under	lying cause give	en in Part I.		tobacco us Yes 2□		the cause of death? bably 4 Dinknown
The Bearing	w requ	iete	N.						24a. Was	s an	246. Were aut	oosy findings available
		Completed							- auto	psy ormed?	prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
# //	Physician: This certifice	Be	25. Was case referred to medical examiner?	ospital:			I Othe		Death (Check only		/	itarias
EN	Phys	5	1 Yes 2000	1 L Inpatie	nt 2 ER/Out		DOA Othe	4 🗀 Nursin	g Home 5 Res 28d. Describe		Other (Speci	MILE TILL
W	Attending Ir death.	tion	1 DNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Da)	y Year) In	ijury	Work	(?` Yes 2∐No				
AVEN Division of	or Attendiate death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, far	m, street,	factory, office		28f. Location	(Street and	Number or Rur	al Route Number,
ء ر	Hospital or thours afte Funeral Dir tely filled in	Cer				V-152						
7	To the Hospital of within 24 hours at To the Funeral D completely filled is	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	er: On the basis of and manner sta	examination and	Vor investi	gation, in my op	ie, date and pi pinion, death o	ace, and due to the ccurred at the time,	date and	olace, and due t	o the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	Pin		M	29c. License	number	7	29d. Date	signed (Month,	Day, Year)
	0 110		30. Name and address of per on what	mpleted cause of de	eath (Item 22a)	Type Print	1//	201/2		1/	1///	110
\mathcal{C}_{i}	K (e)		John Mita	VIAC-	49/1/1	nde	rulope	of KI	1 Bill	0,1	10/2	12/8
	Sta Regist		SEP 2 5 2006	32. Registra	ar's Signature	de la		-,	,	9"		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 530 PM September appenter eNNO 23 2006 /Medical Facility Name (If not institution, 4b. City, Town, or Location of Death 4c. County of Death Examiner baltmorg MIVERSITU g. lor uland BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 2 🖾 F Director 299-06-3134 MAY 1. OHIO Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Director MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 CHIEFTAN LANE 21713 death U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie. Importent: If item 27 is marked other th any injury or other traumatic event, III.s. Once. 0 NONE NEVER EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JUSTIN LEE CARPENTER MONICA_LEIGH ZUCCONI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MONICA L. ZUCCONI/MOTHER 310 CHIEFTAN LANE, BOONSBORO, MARYLAND 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5 Other (Specify) SMITHSBURG CREMATORY 9/29/2006 SMITHSBURG, MARYLAND 21. Signature of F 22. Name and Address of Facility 7606 Old National Pike Paul m. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Pah1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** brain /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed the attanding physicien end thed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Deed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Sign After thi 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending after death.

Director: Aff investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 | Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GreenE Street outer EMAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 26 2006 Registrar

			1 - For State Registrar	State of Ma	ryland			it of He e of D		Mental Hy	giene, Reg. No,	2000	31743
			1. Decedent's Name (First, Middle, La	ast)						2. Date of D	eath Day	Year	3. Time of Death
	Physicia /Medic		Michael J. C	roghan						10/1/		rear	4:00 A M
,	Examin		4a. Facility Name (If not institution, gi				4b. City,	Town, or Lo	ocation of Death)	4c.	County of Deat	th *
			7514 Ridge Road				Fre	deric	.C.		F	rederio	k
	Funeral			Sex 7. Age	(in yrs. la	st birthday)	If Unde Months		f Under 24 Hrs. Hours Min.	8. Date of Bi	av. Year)	9. Birt	hplace (State or Foreign
	Director		166-12-5322	8	5	Yrs.				8/31/	1921		MD
)	B		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Lo	cation						10d. Inside City Limits
	aryii	ō	MD Frede	rick		ederio							1 ☐ Yes 24∑XNo
	28a-1	ect	10e. Street and Number	LICK	11,		10f. Zij	Code			10a Citi	zen of What Co	unito/2
	NIII	by Funeral Director									USA		, dility i
	98II	erai	7514 Ridge Road	12. Was Decedent E	ver in U.S.	13.1		702	nanic Origin? (S	pecify Yes or N		14. Race - Ame	nican Indian.
	r iten	품	1 □ Never Married 2 □ Married	Armed Forces? 1 ⊠Yes 2 □ N			f Yes, spe	cify Cuban,	anic Origin? (S Mexican, Puert	o Rican, etc.)		Black, Whit	
3	urs a		3 √Widowed 4 □ Divorced	If Yes, Give Year or Dates: 4			1 🗌 Yeş	2 √ No	Specify:			Specify: Wh:	ite
	illed within 72 hours after death with the Maryland Hygiene. Whet then "natural", or items 23s or 28s-1 show ant, the Madical Examiner must be notified at	Completed	15. Decedent's 8			16a. Deced	dent's Usu	al Occupation	on	tune.	16b. Ki	nd of Business	
	9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	pie	(Specify only highest gi	College (1-4or 5-	F)	life. L	DO NOT	se retired)	ring most of wor	king			
1	er th	00	12			Owner	r/ Op	erato				spital:	ity
2	a H H	Be (17. Father's Name (First, Middle, Las	t)				14	8. Mother's Nan		e, Maiden	Sumame)	
X	Men Men arke	မ	Michael J. Crogh							Brown			
<u> </u>	and le m	4.7	19a. Informant's Name/Relationship				-		d Num <i>ber or Ru</i> d Frede				Zip Code)
	and leelth m 27 her t		Laura Metcalf	Daughter	_	ce of Dispo			d Flede	Date Date		cation - City or	Town Chair
5	it of the		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		Cer	metery, cren	natory or t	other place)	10.10				
	tant:		4 □ Donation 5 □ Other (Spec		Smi				ry 10/2			hsburg	
g	permit. Pages 1 and 2 should be lined within 72 hours after death with the Maylian Department of Heelith and Mental Hygiene. Important: If them 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Modical Examinar must be notified at once.		21. Signature of Funeral Salvia Life	1/4/	10017				^{of Facility} Ke urch St				eral Home 21701
			23a. Part1. Enter the disease, or con shock, or heart lailure. List on	nplications that caused	the death.	Do not ent	er the mo	de of dying,	such as cardiac	or respiratory	arrest,		Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	Metastic		tate	Cance	r					Onset and Death
	/Medical		resulting in death)	Due to (or as a									
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ζ.	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
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	cate to physic the to	edical	•	d								_	
? ;	ding p	₩.	IF FEMALE:	23c. If yes, outcome of	of prognan	014							
2	ath c ettenc for us	an	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal o	death 3	Ectopic p				1 2	23d. Date of del Month	livery Day Year
j	the 6	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant at t 9∐Unknown	lime oi dea	atn 5	J Otner (s)	эөспу)					
Ŀ	inat ti ed by detac		Part II. Other significant conditions	contributing to death bu	t not resul	ting in the u	nderlying	ause given	in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
ה מ	sign d ba	d b								1 🗆	Yes 21	dNo 3□Pr	obably 4 Unknown
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5	n: In icate r, pag	ပ								1 ☐ Yes	212 No		2□ No
	certif recto	Be	25. Was case referred to medical examiner?	Hospital:				Other	26. Place of Dea				4
5 6	this ral di	10	1 Yes 2 No 27. Manner of Death	1 Inpatier		R/Outpatien 28b. Time of		JA	4 Nursing h	ome 5 Res 28d. Describe		Other (Spe	cify)
5 :	After fune	턀	Natural 5 ☐ Pending	(Month, Day	Year)	Injury	м	28c. Injury a Work? 1 □ Ye	s 2 □No	200. 200020		,	•
2	deat deat ctor: y the	fica	3 Suicide 6 Could not	be 29a Place of Inju	ry - At hon	ne, larm, str	eet, lactor			28I. Location	(Street an	d Number or Ri	ural Route Number,
<u> </u>	eftar eftar Dire	Certification:	4 Homicide	building, etc	. (Specify)			,,		City or To	wn, State)	
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	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner stat	ı u d.		20	c. License r	number		29d. Dat	e signed (Mont	h, Day, Year)
1	Z Z Z		Social Services and the or control	llain	M)	23	0	6675			CT. 2,	
			, W /		ath (tree	02-) /7 -	Deine	P (
	W		30. Name and address of person who Dr. Allgaier M	D 610 Ninth	Aver	iue Br	unsw	ick, N	4D 21716				
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registra			- 0	2					
			0.07 / 6 /	IIIh MA	14	Pa	2000 1						

		•	1 - For State Registrar	State of Maryland	d / Department of F Certificate of		Hygiene	31744
ı	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)	URRY	4b. City, Town, o	2. Date of Month	Death Day Year 1007 23, 200 4c. County of Dea	
4	Funeral Director	er	WASHINGTON COUNTY 5. Social Security Number 579-1.4-6867	HOSPĮTAL	HA	GERSTOWN	WASHI Birth Year) 9. Birth Co. 4, 1918 WAS	NGTON hplace (State or Foreign suntry) HINGTON, DC
	Maryland a-f show ilied at	tor	Usual Residence of Decedent		y, Town or Location	HARPSBURG		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Ie marked other then "natural", or Iteme 23e or 28e-f show other trsumatic event, the Medical Examiner must be notified at	by Funeral Director	10e. Street and Number 4909 GENERAL GORD 11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	.S. 13. Was Decedent of high Yes, specify Cub	21782 dispanic Origin? (Specify Yes of an, Mexican, Puerto Rican, etc. Specify:	Specify:	A. erican Indian, ee, etc.
21215-0036	within 72 hour iene. 'then *natural' 'the Medical Ex	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates: cation a completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire CLERK	during most of working	16b. Kind of Business	VHITE Vindustry Y COURT
Maryland 2	should be filed nd Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) HUSTON HANGER			18. Mother's Name (First, Michael HELEN PFEIFFE	ddle, Maiden Surname)	
	1 and 2 sho Health and Iem 27 Ie m		JOHN N. MULLICAN/S 20a. Method of Disposition	ON 20b. P	4908 GENERAL Place of Disposition (Name of	and Number or Rural Route Nu GORDON CIRCLE, Date	· ·	MARYLAND
Baltimore,	permit. Pages Depertment of I Importent: If Ite eny Injury or of		1 Burial 2 Cremation 3 R 4 Commention 5 Other (Specify)	emoval from State SMT	THSBIRG CREMAT	ORY 9/25/2006	SMITHSFURG Old National	the state of the s
<u>е</u>	89E 8		23a. Part I. Enter the disease, or complishock, or heart failure. List only or	Paul M. De		BOORS	boro, Marylan ry arrest,	Approximate
				ne cause on each line.				Interval Between Onset and Death
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760,	/Medical Examiner	cal Examiner	Immediate Cause (Final disease or condition	Due to (or as a consequence to consequence) Due to (or as a consequence) Due to (or as a consequence)	vium Difficulture of: Trait Inguence of):			Onset and Death WEEKS
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Division of Vital Records, P.O. Box 68	Jing Physician: The law requires that the death certificate be executed by the death certificate has been signed by the ettending physicien and funeral director, page 2 should be detached for use as the buriat-transit	Medical Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of the consequence of t	uence of): Tract In uence of): uence of	ren in Part I. 23e. If CONC. 24a. Var 26. Place of Death Check on the rent in Part I. 28d. Description at the time, and due to opinion, death occurred at the time in the rent in the part in the rent in the	Month Did tobacco use contribute to the course of the cause (s) and manner a me, date and place, and during the cause (s) Date signed (Montrible Course) Month 24b. Were a prior to death? 24b. Were a prior to death? 1 Yes 24b. Were a prior to death? 1 Yes 24b. Were a prior to death? 24b. Were a prior to death? 1 Other (Specific Accordance) 1 Other (Specific Accordance) 25c. Other (Specific Accordance)	Onset and Death WEEKS DAW livery Day Year of the cause of death? robably 4 Minknown utopsy findings available completion of cause of secify) tural Route Number, s stated. e to the cause(s) th, Day, Year)

		í	1- For State of Maryland / Department of Health and Maryland / Certificate of Death	Mental Hygien	3 U U C '	31745
*	Physici		Decedent's Name (First, Middle, Last) ANGUS GRAY CAMPBELL	2. Date of Death Month D	ay Year	3. Time of Death 0:58 A M
	/Medio		4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	externiter 4	County of Death	P.5
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 192–18–6753 HXM 2 F 84 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year OCT . 4, 19) Countr	
	in the Maryland or 28a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MARYLAND CHARLES WALDORF		100	d. Inside City Limits 1 ☐ Yes ② No
-	2 2	Funeral Director	10e. Street and Number MORNINGSIDE HOUSE 10 VILLAGE STREET, APT 305 10f. Zip Code 20602	10g. C	itizen of What Country	
920	or ite	[출	11. Marital Status 1 Never Married 2 Married 3 Warlied 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Was Decedent Ever in U.S. Armed Forces? 1 No 1943 1 Yes, Specify Cuban, Mexican, Puerto 1945 1 Yes, Give Year or Dates: 1945	pecify Yes or No- p Rican, etc.)	14. Race - Americar Black, White, et Specify: WH]	c.
Maryland 21215-0036	n 72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) NERCHANT SEAMAN	king 16b.	Kind of Business/Indu	stry
yland	s 1 and 2 should be filed within f Heelth and Mental Hygiene. Itam 27 is marked other than other traumatic event, tha M	To Be C	MATHEW CAMPBELL ELIZA	ne (First, Middle, Maide ABETH GRAY		00450
	is 1 and 2 short the self that and its m 27 is m other traum		19a. Informant's Name/Relationship (Type, Print) MARIA A. CAMPBELL - WIFE 40295 NEW MARKET TURNER 20b. Blace of Disposition (Mars of	R RD., MECH	ANICSVILLE	E, MD
Baltimore,	permit. Pages to Depertment of Himportant: if its any injury or ot once.		1 Liburial 2 Dicremation 3 Linemoval from State	2006 WA BOX 156,	Charles State of	RYLAND YLAND 20604
8760,	Physician physician and physician and physician and physician and the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one subset on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	SCLENN	. II	oproximate tterval Between Onset and Death
.O. Box 6	death certifi e ettending od for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of delivery Month D	ay Year
rds, P	w requires that the sbeen signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the	1
al Reco	The la ete has page 2	Completed		24a. Was an autopsy performed?	prior to comp death?	y findings available bletion of cause of
Vita	Physician: The this certificate ral director, pag	To Be	examiner?	th Check only one	6 □Other (Specify)	
Division of Vital Records,	ding After fune	Certification; 7	27. Manner of Death Natural 5 Pending (Month, Day Year) 28b. Time of 1njury 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28b. Time of 28	28d. Describe how injuted a 28f. Location (Street a City or Town, State	ury occurred nd Number or Rural F	Route Number,
	To the Hospital or Attentwithin 24 hours effer deatl To the Funeral Director:	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge death occurred at the time data and place one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated	and due to the causel red at the time, date an	and manuer at state of place, and due to the	ed ne cause(s)
	To the within To the comp	Ž	29b. Signature and title of certifier 2042Q	29d. D	ate signed (Month, Da	106.
7	8 til	ate	30. Name and address of person who completed cause of death (Item 23a) (Type-Print) COORCE H. WOHNEY M.D. 11345 PEMDO 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature	ohe zowa	he wald	103 solo

			1 - For State Registrar	State of Maryland		artment of		nd Menta		ne 2006	317	46
	Physici	an	Decedent's Name (First, Middle, Last)					Me		Day Year	3. Time of	
	Physici /Medic	al	Loretta B. Cannon			4h Cihi Toum	or Location of [tember	17, 200		A ^M
	Examin	er	4a. Facility Name (If not institution, give stress 3207 Eastbend Cour			Abingdo		Death		Harford		
7	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Yea Months Day:	r If Under 24	Min. (M	ite of Birth	ear) Co	hplace (State o	r Foreign
- 3	Director		438-98-4021 Usual Residence of Decedent	^{4 2⊠F} 89	Yrs.	,		01/	/28/191	7 Lou	isiana	
	yland 10w		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside Cit	-
	e Mary	ctor	Maryland Harford	Abir	ngdon						1 X Yes	2 🗆 No
	with th	Directo	10e. Street and Number			10f. Zip Code			USA	Citizen of What Co	ountry?	
	ns 234	Funerai	3207 Eastbend Cour	. Was Decedent Ever in U.	S. 13. V	21009 Was Decedent of f Yes, specify Cu	Hispanic Origin	n? (Specify Y		14. Race - Ame		
و	after o	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 No ff Yes, Give		fYes, specify Cu 1 □ Yes 2000N		Puerto Rican,	, etc.)	Black, Whit	e, etc.	
003	filed within 72 hours after death with the Maryland Hygiene. ther than "natural; or Items 23s or 28s-f show int, the Madical Examination in incilling at	d by	3X Widowed 4 □ Divorced	Year or Dates:					4.01	Wh	ite	
7	in 72 t	Completed	15. Decedent's Educa (Specify only highest grade of	completed)	16a. Deced (Give life. I	dent's Usual Occ kind of work don DO NOT use retii	upation ie during most o red)	of working	160	o. Kind of Business	industry	
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Home :	Maker	7		(Own Home		
Maryland 21215-0036	0 = 0 5	Be	17. Father's Name (First, Middle, Last)							den Sumame)		
<u> </u>	should be and Mental marked o umatic eve	2	Pascal Bacala 19a. Informant's Name/Relationship (Type	Print)	19b Mailir	og Address (Stre		lda Reg or Bural Bou		ity or Town, State, .	Zip Code)	
<u>S</u>	and 2 s salth an n 27 io r		James Cannon/ Son	,						1D 21009		
Baltimore,	of Hea of Hea rothe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer	20b. P	lace of Dispo emetery, crea	sition (Name of matory or ether p en of	lace)	Date	200	c. Location - City or	Town, State	
Ĕ	Pages ment of ant: if it ury or o		4 □Donation 5 □ Other (Specify)	noval from State	Memor	ies	109			etairie,		
Ball	permit. Pages 1 and 2 should by Department of Health and Menta Important: if item 27 is marked any injury or other traumatic a <u>once.</u>		21. Signature of Funeral Service Licensee							vans Fune MD 20715	ral Hom	.e
150	Physician		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.					oratory arrest,		Approximate Interval Bette Onset and I	ween Death
	/Medical Examiner		resulting in death)	FUNCTI Due to (or as a consequence of the second of the se	uence of):			<u> </u>		2 0		
*		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ		TIC	CARD.	FOVA	SCELA	DISEASE	yeu	<i>y</i> 3
	outed d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.									
,092	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as a consequ	uence of):							
ထ	icate be ex physician s the buria	ledicai	d .									
Вох б	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome of pregna						23d. Date of de	livery	
o.	at the death by the atte	Physician/M	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown		_Ectopic pregnar _Other (specify)				Month	Day '	Year
<u>α</u>	es the gned be de	ρ	Part ff. Other significant conditions control	ributing to death but not resi	ulting in the u	nderlying cause	given in Part I.	2		cco use contribute t 2 XNo 3 ☐ P	o the cause of c	
Records,	aw requir as been si 2 should	Completed						2	4a. Was an autopsy	24b. Were a	utopsy findings completion of c	available
<u>~</u>	The tav ate has page 2	Com						1	performe	d? death? No 1 ☐ Yes	2 □ No	
Vital	Physician: The Ithis certificate har all director, page	Be	25. Was case referred to medical examiner?	spital:		10		of Death (Che				
ō	Phys r this sral dir	2	1 Yes 2 No	28a. Date of Injury (Month, Day Year)	28b. Time o		4 □ Nurs njury at Vork?			injury occurred	ecify)	
lon	nding F ath. r: After e funer	atior	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	fnjury		Vork? ☐ Yes → 2 ☐ No	0				
Division of	i Diff o	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)		reet, factory, office	се	28f. L	ocation (Stree Dity or Town, S	et and Number or R State)	ural Route Nurr	nber,
	Hospita 14 hours Funeral tely fille	edical C	29a. Cartifier 1 Certifying Physic (Check only one)	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the evestigation, in m	time, date and y opinion, death	place, and d	ue to the caus the time, date	se(s) and manner a a and place, and du	s stated. e to the cause(s	s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Lice	ense number	100	29d	. Date signed (Mon	th, Day, Year)	
)			mo mo			100	0056	60/	. گ	zistember	19.	2006
	0		30. Name and Theress of person who com	npleted cause of death (ften	23a) (Type,	Print)	Tun(22)	RD	BEZ	AER N	0 21	0/4
-30	8	ate	JOSEM ANGEL 31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	Z 3.17	, 000	7.00			- 21	-/7
	Regist			06		hart .						

ORIGINAL

				partment of Health and Mertificate of Death	ental Hygier	2006	31747
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Yeer	3. Time of Death
	/Medic	al	Robert Chab, Jr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	September	4c. County of Deal	
	LXdiiiii	i Ci	106 Hawthorne Green Circle	La Plata		Charles	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 5.06 - 3.2 - 8.1.1.0 1 ☑ M 2 ☐ F 7.5 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birt	thplace (State or Foreign ountry)
Η,	Director		506-32-8119 1⊠ M 2		July 9, 19	31 Neb	raska
	arylan ehow	_	10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits
	the M	ecto	Maryland Charles La Pl	ata 10f. Zip Code	100	Citizen of What Co	1X Yes 2 No
	h with	E D	106 Hawthorne Green Circle	20646	Tog.	USA	•
	tems tems	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Ame Black, Whit	
336	filed within 72 hours after death with the Maryland Hygiene. Hygiene. then "natural", or Itema 23a or 28a-f ehow ent, it a Madical Era ciner must be notified at	Š	1 □ Never Married 2\(\infty\) Married 1\(\infty\) Yes 2 □ No	1 ☐ Yes 2)X No Specify:		Specify:	White
2-0	72 hou	eted	15. Decedent's Education 16a. Dece	edent's Usual Occupation e kind of work done during most of workir	16b.	Kind of Business	Industry
121	within ene. then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			HC A E
		Be Co	17. Father's Name (First, Middle, Last)	ief Master Sergeant 18. Mother's Name	(First, Middle, Maid		USAF
ylar	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or liems 23a or 28a-1 show aumatic event, it a Medical Espainer must be notified at	To B	Robert John Chab	Velma I	va Endico	tt	
Mar	d 2 sho			ling Address (Street and Number or Rura			,,
<u>ē</u>	s 1 en f Heall frem 2 other		20a. Method of Disposition 20b. Place of Disp	Hawthorne Green Cir	The state of the s	Location - City or	
altimore, Maryland 21215-0036	Pege nent o ant: If ury or		1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Huntt Cre	ematory or other place) 9-21-	06 Wal	dorf, MD	
Balt	permit. Peges 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic events.			22. Name and Address of Facility		Washing	ton Road
	46244		23a. Part1. Enter the disease, or complications that caused the death. Do not en	Huntt Funeral Home		MD 20601	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	CANCER			Interval Between Onset and Death
	/Medical Examiner		resulting in death) a. Due to (or as a consequence of):				
		ē	Sequentially list conditions, b. Due to (or as a gunsacquence of):				
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
8760,	ate be executed thy sicien and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
687	ficate physics the t	edical	d				
Box	death certific e attending p id for use as	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of deli	ivery
	0 0 0	by Physician/Me		Other (specify)		Month	Day Year
<u>.</u>	The law requires that the site has been signed by thogge 2 should be detached.	y Ph	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	use contribute to	the cause of death?
rds	en sign	ed b			1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Winknown
ည် မ	law requ	Completed			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
			TOT WAS A STATE OF THE STATE OF		performed?		2 🗆 No
	ysici is cei	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death	e 5 Residence	6 □Other (Spec	n(v)
Division of	ding Ph Ater th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of Month, Day Year) Injury		8d. Describe how in		
ISIO	Attend death. ctor: /	Icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st	M 1 Yes 2 No	8l. Location (Street	and Number or D	m I Bouto Marko
	2552	Certification;	4 Homicide determined determined building, etc. (Specify)	reet, factory, office	City or Town, Sta		rai Houte Number,
	Hospital or 24 hours afte Funeret Dirietely filled in	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge deal of the control of the basis of examination and/or in and manner stated.	th secured at the time, date and place as avestigation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as nd place, and due	etated to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	29c. License number	29d. E	Date signed (Month	n, Day, Year)
			I house M Matte	02835	2 7	121/06	
1	भारता		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 1 col atom	1	v > 0	1106
نل	Sta	te	31. Date filed (Month, Day, Year) 32. Legistrar's Signature	Land 1	V		0 40
	Registr	ar	SEP 2 2 2006 Allew D. A.				

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar	Certifica	te of Death	Reg. No. 20	06 3174
Madi	Physic ical Exam		1 Decedent's Name (First, Middle,Last)	1.		Date of Death Month Day Year	3. Time of Death 1429 hrs
yieu:	Cai Exaiii	mei	Richard Dale D 4a. Facility Name (if not institution, give street	arling	4b. City, Town, or Location of Dea	October 1, 2006 4c. County of E	
	1		Memorial Hospital at Easton	,	Easton	Talbot	
	Funeral Director		5 Social Security Number 218-48-8001 6. Sex 1	7. Age (In yrs. last birtho			9. Birthplace (State or oreign Maryland
_	ny		Usual Residence of Decedent 10a State 10b. County	10c. City, Town or	Location		10d Inside City Limits
	d now a		MD Caroline		enderson		1 X Yes 2 No
	anylan 8a-f sl at one	Director	10e Street and Number		10f. Zip Code	10g. Citizen of What	**
	ith the Maryland 23a or 28a-f show any <u>notified at once.</u>	Dire	302 Mill Street		21640	United S	tates
	h with ms 23 be no	Funeral		Vas Decedent Ever in U.S.	13 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer		American Indian, Black,
	AID 27215-UU.36 2 should be filed within 72 hours after death with the Maryland hand Mennal Hygien Mennal Hygien 77 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once matic event, the Medical Examiner.	Fun	1 X	Yes 2 No	1 Yes 2 No specify	Specify. W	
	rs afte ural". mine	by	3 Widowed 4 X Divorced If Yes, or Date 15. Decedent's Education (Specify only high	es:	ecedent's Usual Occupation (Give kind o		
	5-00.36 led within 72 hours after Hygiene "natural", other than "natural", the Medical Examiner.	Completed	Elementary/Secondary (0-12) C	ollege (1-4 or 5+)	ring most of working life. DO NOT use r	retired)	ŕ
è	vithin ene er tha	ldш	6th	Wat	cerman	Fishin	g
į	Z1Z15-UU36 uld be filed within 7 Mental Hygiene marked other than c event, the Medica		17. Father's Name (First, Middle, Last)	omline C.		me (First, Middle, Maiden Surname)	Callahan
2	212 uld be Menta marko	To Be	Robert Charles D. 19a. Informant's Name/Relationship (Type, P		Mailing Address (Street and Number of	ce Williamson I or Rural Route Number, City or Town,	
9	Baltimore, MD 21215-500 permit Pages I and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the M.		Beatrice Callahan/Mo		0. Box 54, Gold		
	re, l s l and f Heal ff item er tra		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re	20b. Place of	Disposition (Name of cemetery, y or other place)	Date 20c. Location - Ci	
	Page Page ment o tant:		4 Donation 5 Other Specify	Hillcre		/06/06 Federal	
-	Saltimore, sermit, Pages I ar Department of Her Important: If ite njury or other tr		21. Signature of Funeral Service Licensee	DVD)	22. Name and Address of Facility	ramptom Funeral	l Home, P.A.
	Physician		Michael F. Eskow (per 23a Part I. Enter the disease, or complication		216 N. Main St.,	rederalsburg, MD	21632 Approximate Interval
	/Medical		failure. List only one cause on each line	e.	clerotic cardiovascular		Between Onset and
	Examiner		Part 14 1 1 1 1 1 1	(or as a consequence of)	, 49	The state of the s	
		io.	Sequentially list conditions, if any, leading to immediate b.	(or as a consequence of):			
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
	ted 1 ansit	Exa	events resulting in death) Last Due to	(or as a consequence of):			
	8 / 60, ifficate be executed ng physician and as the burial - transit	n/Medical	XUNPENDED X AME	NDED #21 por	TI 220 27 nowME 0960	10/12/06 TT	
0	8/6U, tificate be ng physic as the bur	/Mec		. If yes, outcome of pregnancy	FH, 23a,27,perME,g860,	23d Date of de	livery
•	8 E C		past 12 months?	Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic preg Other (Specify)	nancy Month	Day Year
Ċ	be death certific the attending	Physicia	1 Yes 2 No 9 Unknown 9	Unknown	· Other (opeciny)		
(tal Records, P.O. Box 6 rian: The law requires that the death cer certificate has been signed by the attendi ector, page 2 should be detached for use:	by P	Part II. Other significant conditions contri	buting to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobacco use contribu	
	15, 1 Aguires sen sig uld be	Completed					re autopsy findings available
	COFC law re has be	l ble					or to completion of cause of
C			25. Was case referred to medical		26 Place of Death (Chec		Yes 2 No
Š	VITAI ysician: his certif director,	o Be	examiner? 1 ✓ Yes 2 No	l: 1	Other:		Other
	1 Of VIII Ing Physic After this a		27. Manner of Death	Ba. Date of Injury (Month, Day, Year) 28b. Til	me of Injury 28c Injury at Work?	28d Describe how injury accurred	
	SION vttendi death ctor: y the f	lät	1 X Natural 5 Pending 2 Accident Investigation		1 Yes 2 No		
	LIVISION OF VITAL RECORDS, tall or Attending Physician: The law requir and refered and reduced and an Infrared and Prince or After this certificate has been set of in by the funeral director, page 2 should I	Certification:	determined	8e. Place of Injury - At home, farr Spe <i>cify)</i>	n, street, factory, office building, etc	28f. Location (Street and Number of Town, State)	or Rural Route Number, City
•	Ur Hospital of 4 hours a: Funeral E		290 Contilion		n occurred at the time, date and place, a	nd due to the cause(s) and manner as	started
-	DIVISION Of VITAL 1 To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certificompletely filled in by the funeral director,	Medical	one) 2 Medical Examiner: On the		estigation. in my opinion, death occurre		
	E S E O	M	29b Signature and title of gertifier	1/1	29c License number		(Month, Day, Year)
			XMMX	101	O.C.M.E.	October 2, 20	006
	7		30. Name and address of person who comples Susan Hogan MD. Assistant		Penn Street, Baltimore, MD 2	21201	
	S	tate	31. Date filed (Month, Day Year)	32. Registrar's Signature			
	Regis			palacine All 1	Goarle		

State of Maryland / Department of Health and Mental Hygiene

				State of Maryla		tificate of			Reg. No. 0 1	06 3	1750
-4	Physicia	an l	1. Decedent's Name (First, Middle, Lest)			-		2. Date of De	ath Day	Year 3.	Time of Death
No.	Physicia /Medic		ELWOOD	RICHARD	DADE				IBER 14	2006 5	:00 PM
100	Examin	er	4a Facility Name (If not institution, give s				4b. City, Town, or L				
		9	GLADYS SPELLMAN			If Under 1 Year	LANDOV			E GEORG	
	Funeral Director		5. Social Security Number 6. Sex 152 152 Usuel Residence of Decedent	7. Age (in yn	s. last birthdey) Yrs.	Months Days		8. Date of Bird (Month, Da OCT. 1.	y, Year) 3 1915	PA	(State or Foreign
	ylend		10a. Stete 10b. County	10c. C	City, Town or Lo	cation					side City Limits
	ath with the Meryler 23a or 28a-f show	ģ	MD PRINCE GE	ORGE'S L	ARGO					1.	∐Yes 2□No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?	
	th w	la l	500 N. HARRY S. T	RUMAN # 422		207	774		U.S.	Α	
020	within 72 hours efter death with the Meryland ene. than 'natural', or items 23a or 28a-f show he Medical Evarrinar must be notitled at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	I2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decedent of f Yes, specify Cub I □ Yes 2∑XNo	Hispanic Origin? (Sp ean, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Raci Btac	e - American Ind k, White, etc. : BLAC	
2-0	n 72 hours natural;	ted	15. Decedent's Educ (Specify only highest grade	cation	16e. Deced	lent's Usual Occu	pation	cina	16b. Kind of Bu	siness/Industry	
Maryland 21215-0020	D 70 -	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		CK DRIVE	during most of worked)	9	PRIV	ATE	
nd	be filed tral Hygind of other event, il	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Surnam	e)	
yla	Mer Mer arka	2	RICHARD THOMAS				LOUISE	DADE			
Mar	d 2 shoth and thand 7 is mutanm	1	19a. Informant's Name/Relationship (Ty)			-	t and Number or Ru				
e, .	1 and Health em 27	- 1	EDITH S. DADE/WIF 20a. Method of Disposition				S. TRUMAN	Date	20c. Location		
Baltimore,	S to I		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of natory or other pla NAT L CE			6 LAUREI	-	
Balt	permit. Peg Department Important: I any injury o	- 1	21. Signature of Funeral Service License	lass		Name and Address	ess of Facility J.		KINS FUI ER,MARYI		OME 0785
	Mark Hall		23a. Part1. Enter the disease or complication of the shock, or heart failure. List only on	cations that caused the dec						Appr	roximate val Between
	Physician /Medical		Immediate Cause (Final	SEPSIS	}					Onse	et and Death
462	Examiner		disease or condition resulting in death)	Due to	(or as a conseq	uence of):					
	Si &	lue	- b	DEMENT	CIA						
	ficete be executed physician end is the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate		(or as a conseq						
60,	be ey ician burie		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ALZHE	MERS TY	YPE				į	
68760,	rtificete be executed ng physician end set he buriel-transit	Medical	that initiated events resulting in death) Last		or as e consequ	uence of):				1	
Вох	death cer e ettendin ed for use	Physician/M	d	•							
P.0.	the de by the e	ysic	Part II. Other significant conditions con-	tributing to death but not re	sulting in the un	nderlying cause gi	ven in Part I.		obacco use cor		
	res thet the designed by the e	by Ph						1	Yes 2½∏ No	3 ∐ Probably	4 🗌 Unknown
Records,	law requires thet as been signed b 2 should be det	Completed b				_			an autopsy med?	available	utopsy findings e prior to ion of cause ?
Re	The law ete has page 2:	mo						101	ras 2KINo	1 ☐ Yes	2 € No
Vita	ilclan: Th certificete rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th (Chack only c	ne)		
of <	Physician: rthis certific rral director,	2	1 ☐ Yes 2 ☐ ¥No		☐ ER/Outpatien	1 3LI DOA			tence 6 □Othe		
	ng Pl	ë	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. tnju Wo		28d. Describe	now injury occurr	red	
Division	i or Attending P effer death. Director: After i d in by the funera	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre]Yes 2□No	28f. Location (S City or Tov	Street and Numb vn, Stete)	er or Rural Rou	te Number,
_	To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by th	edicai Ce		ician: To the best of my kr er: On the basis of examin and manner stated.							cause(s)
	o the	Me	29b. Signature and title of certifier)	29c. Licen	se number		29d. Date signed	d (Month, Day,	Year)
	FSFO		1 Pmc	linde	LAR	D01	.852		SEPTEMBE	ZR 19	2006
	n0 16	2/	30. Name and address of person who cor	mpleted cause of death (Ite	m 23a) (Type, I				OUL LUNDI	-10 TO	2000
_ (UCC		PAUL A. DEVORE M.	D. 4203 QUEE	NSBURY	RD HYATT	SVILLE, M	ARYLAND	20781		
	Sta	te	31. Date filed (Month, Day, Year) SED 2. 5. 2096	32. Registrar's Sign	nature	R.					

	1 - For State Registrar	State of Marylan		tment of H			giene 0	06 3175		
Physician /Medical	WIISON COIGND	us Dodson					Day			
Examiner	4a. Facility Name (If not institution, give Doctor * S Hospi 5. Social Security Number 6. Se	tal		Ib. City, Town, or Lanhan If Under 1 Year	Location of Deati			e George		
uneral irector		7. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in yrs.</i> 1. Age (<i>in</i>		Months Days	Hours Min.	8. Date of Birth (Month, Day Apr. 17	r. Year)	9. Birthplace (State or Forei Country) Maryland		
Important: If Item 27 is marked other then "natural", or Items 23a or 28s-1 show any Injury or other traumatic event. The Medical Examinar must be notified at once. To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City 10d. Inside									
ural', or items 23, I Examinar must d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Wes 2 □ No 2 / 43 If Yes, Give Year or Dates: 3 / 46 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto			pecify Yes or No- o Rican, etc.)	o- 14. Race - American Indian, Black, White, etc. Specity: Black				
t. the Medical E	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	Education grade completed 16a. Decedent's Usual Occupation grade completed 16a. Decedent's Usual Occupation work done during most of work life. DO NOT use retired Mailroom Clerk			king	Governm				
atic event.	17. Father's Name (First, Middle, Last)	er's Name (First, Middle, Last) 18. Mother's Name				ne (First, Middle, eth Wils	irst, Middle, Maiden Sumame)			
her traum	19a. Informant's Name/Relationship (T	/ Wife	10100	Campus W	ay South		Largo	, Md. 20774		
any Injury or ot <u>once</u> .	20a. Method of Disposition 1	For	t Lincol	ame and Addres	ery 9/25 s of Facility al Homes	/2006 B	Brentwoo	City or Town, State		
should be detached for use as the burial-transit a bot left by Physician/Medical Examiner	23a. Part 1. Enter the disease or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cade on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, bauting to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death Onset and Death Approximate Interval Between Onset and Death Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Onset and Death Approximate Interval Between Onset and Death Onset and Death Approximate Interval Between Onset and Death Onset and Death									
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown					23d. Date of delivery Month Day Year			
ted by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION				23e. Did tobacco use contribute to the cause of dea 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ York					
or, page 2 should e Completed		TROL					No 1	fere autopsy findings availab ior to completion of cause of eath? □ Yes 2□ No		
To Be	examiner?	Hospital					th (Check only one) ome 5 ☐ Residence 6 ☐ Other (Specify)			
completely filled in by the funeral director, page 2 Medical Certification; To Be Compi	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	17. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be 288. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No					28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
phetely filled	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
E 2	29b. Signature and title of certifier 30. Name an andress of person who co	lizabeth Fas	ICA	BF 2				(Month, Day, Year)		
State	ELIZABETH FASIKA 31. Date filed (Month, Day, Year)	M.A. 515 MAL	N STREE	ET 3017	357	LAUREL	MD 2	0101		

			for State	State of Mary				lental Hygi	0000	01750	
			Registrar		Certi	ficate of D	eath		g. No. 2 UUb	31/52	
н	Physici	ian	Decedent's Name (First, Middle)		T			Date of Death Month	Day Year	3. Time of Death	
	/Media	cal	ELLEN Mi		DURA			09	19 00	104454	
)	Examir	ıer	4a. Facility Name (If not institution,	11		b. City, Town, or I	Location of Death	. 1	4c. County of Death	A :	
	Funeval		5. Social Security Number	6. Sex 7. Age //r	CAMOUS	f Under 1 Year	If Under 24 Hrs.	8 Date of Birth	Allega	place (State or Foreign	
	Funeral Director		164-42-255	51□M 210 56	N. A.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		ntry)	
	p .		Usual Residence of Decedent					J -/(20 10 10		
ING Z I Z I 3-UU35 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Items 23a or 28a-f ehow event, tra Medical Eracia or must be notified at	arylar show	_	10a. State 10b. County	1	City Town or Locat					10d. Inside City Limits	
	8a-f	Funeral Director	Md Alle	TANY	CUMBE.	RLAN	5			1, Yes 2 No	
	with th	ä	10e. Street and Number	P WALSH	1 21	10f. Zip Code		10	g. Citizen of What Cou		
	ns 23	era	11. Marital Status	12. Was Decedent Ever				4 4	U.S.		
_	fter d	E	1 Never Married 2 Marrie	Armed Forces?	If Ye	es, specify Cuban	panic Origin? (Spe , Mexican, Puerto	Rican, etc.)	14. Race - Ameri Black, White,		
0030	al', o	þ	3 ☐ Widowed 4 Divorced	1 🗆	1 ☐ Yes 2 No Specify:				hITE		
<u>ဂ</u>	72 hours after natural', or Ite	Completed	15. Decedent' (Specify only highest	s Education	16a. Deceden	t's Usual Occupat	ion	1	6b. Kind of Business/In	dustry	
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7	led w lygier her th			5+	D) rec		ob Plac		College		
300	be fi	Be	17. Father's Name (First, Middle, L						RAWford		
Ĕ	d Mer narke natic	2	19a. Informant's Name/Relationsh)UVV							
<u> </u>	d 2 sl th and th and theur treur	10	Am ANDA	LAW	Dio. Mailing A	Address (Street ar 人) いじ	nd Number or Rura	A Route Number,	City or Town, State, Zip	Md Weaz	
ก	Heal Heal tem 2	1 9	20a. Method of Disposition		Ob. Place of Disposition cernetery, cremate				Oc. Location - City or To		
2	ages 1 a ant of He it: If item y or othe		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.	3 □Removal from State	cemetery, cremate	ory or other place,	04 0		•	i, Pa. 15349	
altimo	permit. Pages Department of Important: If i eny Injury or o		21. Signature of Funeral Savige		22. N	ame and Address	of Facility	23-CG	FUNERIL	NX-15	
Ď	Depa Impo eny Ir	. 6	1 Salvania	Mush	32	S. SEC	TAID ST.		OTHE CAVE	4	
			23a. Part1. Enter the disease, or o	omplications that caused the	death. Do not enter the	he mode of dying,	such as cardiac o			Approximate	
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition TETASTATIC BUTCAST CANCEY Onset and Death								
,	/Medical		disease or condition resulting in death)	Due to (or as a co		1310011	SI Cri	mac .			
	Examiner		Cognostiathy list conditions	b							
D =		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
2007	cate be executed physician and the burial-transit	Ē	roballing in doubly Eddi	Due to (or as a co	nsequence of);						
0	physi the b	dical		d						·	
X	ding	Physician/Med	IF FEMALE:	23c If was outcome of or	reanancy						
2	eath atten for u	cian	23b. Was decedent pregnant in the past 12 gronths? 1 Yes 21 M N						23d. Date of delive Month	23d. Date of delivery Month Day Year	
9	the d	ysi	1 Yes 2 No 9 Unknown	9□ Unknown	7 G. GOGEN	nor (specify)					
, .	s that	by Pi	Part II. Other significant condition	s contributing to death but no	t resulting in the under	rlying cause given	in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?	
3	quire n sig	d be	1 Tes						2 No 3 Probably 4 Unknown		
3	s bee	Completed	24a. Was an					24b. Were auto	24b. Were autopsy findings available prior to completion of cause of death?		
ב	The I	E						autopsy		mpletion of cause of	
5	rtifice	BeC	25. Was case referred to medical				26. Place of Death	1 Yes 2	No 1 Yes	2 No	
-	ysic direc	70	examiner?	Hospital: 1 Inpatient	2 ER/Outpatient	0#			ce 6 ☐Other (Specif	v)	
To the Hospitel or Attending Physicien: The law requires that the death certification 24 hours elter death. On the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury a Work?		28d. Describe how			
2	eath. or: A	Certification:	2 Accident investiga		M 1 Yes 2 No						
	or At tter d birect n by	Til.	3 ☐ Suicide 6 ☐ Could not be determined 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 287. City or City or					281 Location (Stre City or Town,	on (Street and Number or Rural Route Number, Town, State)		
נ	urs e	ပိ									
:	To the Hospitel of Attending Physicism: The law requires that the death certific within 24 hours elter death. To the Funerel Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	edicai	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)								
	ithin (Mec	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								
	- ≯- 8		200.0					9/19/k	-		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACIDA PODRUMPR WMHS Comberland, N						- (()		
			ALINA POD	RUM Mrz	W M	"HS	Cumb	coldnid	, Md.		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S							
	Registra	ar	SEP 2	5 7008	8- 6						

State of Maryland / Department of Health and Mental Hygienes For State Registrar 31753 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** September 24 2006 A^{M} William J. Donnelly 2:35 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 16, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 2 M 2 □ F 216 16 5622 82 1923 Maryland Director Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f ahow r than "naturel", or itema 23a or 28a-f ahov the Medical Examiner must be notified at 1 Tyes 2 XNo Howard Ellicott City Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4112 Old Columbia Pike 21043 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Modern Machine College (1-4or 5+) Elementary/Secondary (0-12) Co-Owner Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental H William L. Donnelly Anna Mary Kane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Caroyl E. Donnelly/Wife 4112 Old Columbia Pike Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State = 0 permit. Page Department of Importent: If eny Injury or once. 9-25-2006 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal Cell Carcinoma 2 years Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus 11 years Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ьo in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached P.O. the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown Aortic Stenosis plnods 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No page 5 autopsy performed? has certificate 1 Yes 2X No Physicien: the tuneral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D21928 September 25, 2006 30. Name and address of person who com Hed cau e of death (Item 23a) (Type, Print) Leonel Barahona 3459 St. Johns Lane Ellicott City, MD 21042 gistrar's Signature 31. Date filed (Month, Day, Year) 32. State SEP 25 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 21, September 2006 8:00 A M Ralph William Dickerson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 585 Augustine Herman Hwy. Elkton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, December 5, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1₩ 2□F 1919 Virginia 228-07-7556 86 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or 28a-f ahow r than "natural, or Items 23a or 28a-f ahov the Medical Examiner must be nutified at 1 ☐ Yes 21 No Md. Ceci1 Elkton Complèted by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 585 Augustine Herman Hwy. 21921 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 GYes 2 □ No If Yes, Give 942-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Thiokol Sergeant of the Guards ith and Mental Hygie 27 Is marked other r traumatic avent, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be William L. Dickerson Ella Gravley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other tra Nancy L. Ellwood, Daughter 585 Augustine Herman Hwy. Elkton, Md. 21921 Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gilpin Manor Mem. Pk. 9/27/06 Elkton, Md. artment ortant: I Injury o permit.
Departr
Importu
any Inje rvice Licensee 22. Name and Address of Facility 259 E. Main St., Andrew G. Gee F. H. Elkton, Md. 21921 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 5 /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, by Physician/Medical attending for use as IF FEMALE 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2XNo Division of Vital : After this certification and funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 ER/Outpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No M death. Il Diractor: A 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L To the Hospital 39a, Certifier Scrittying Physicism: To the best of my knowledge, death operand at the time, date and clane, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier om cer Ha Do 4823 30. Name and address of person who compfeted cause of death (Item 23a) (Type, Print) West man St LOT IVA CHIH HSU ソレ MD 31. Date filed (Month, Day, Year) 32, Registrar's Signature State SEP 2 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 28a barer me 2860 10-5-06 vt. State of Maryland Department of Health and Mental Hygien 0 0 6

1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year Dill Bessie 2006 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Shock Trauma Center University of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, JULY 9, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Days Hours DELAWARE Director 219-05-0257 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir then "natural", or Iteme 23a or 28e-f ahow The Medical Examiner must be notified at Director KENT HARRINGTON 1 ☐ Yes 2 📉 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4184 BURNITE MILL RD. 19952 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 📆 No δ Specify: Widowed 4 ☐ Divorced WHITE Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygian Important: If Item 27 is marked other til any injury or other traumatic event, the Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN LONGFELLOW Κ. ELLA DOWNS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MYER - DAUGHTER 4188 BURNITE MILL RD., HARRINGTON, DE 19952 KAREN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. OLIVE CEMETERY 9-15-06 SANDTOWN, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BERRY-SHORT FUNERAL HOME DE 19943 Deorge Shou MAIN ST., FELTON, M Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** traumatic Severe day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burist-transit completely filled in by the funeral director, page 2 should be detached for use as the burist-transit CERTIFICATION APPROVED BY MEDICAL EXA Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Dav Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No 1 Inpatient Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certification: 28b. Time of :36 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 500 PM 2 Accident 3 Suicide 1 ☐ Yes 2 No investigation 2006 Fall from NOSPITAL bed 28f. Location (Street and Number or Rural Route Number, City or Town, State) bed 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide General Hospital 540 5. 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Dey, Year) P13154 9-10-2006 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Baltimere 31. Date liled (Month, Day, Year)
OCT 0 5 2006 3 Registrar's Sign Registrar

			For 1 - State Registrar		partment of Health and I e <i>rtificate of Death</i>	Mental Hygie Reg.	ne No2006	31756
	Physic	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examir	cal	Elaine Lucille Doy 4a. Facility Name (If not institution, give st		4b. City, Town, or Location of Deatl		4c. County of Death	8:06 M
	Exami	ier	BUAIS IKA IM and Rehal	2.	Belfir	'	Harford	/
	Funeral		5. Social Security Number 6. Sex	7. Áge (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Cour	
	Director		212-20-8972 Usual Residence of Decedent	93 Yrs.		Nov. 1, 1	1912 Ma	ryland
	arylan ehow	<u>.</u>	10a. State 10b. County	10c. City, Town or	Location		1	Od. Inside City Limits
	the M.	Director	MD Harford 10e. Street and Number	Belcar	nio 10f. Zip Code	100	Citizen of What Cour	1 ☐ Yes 2 No
	h with	ai Di	1401 G Sage Lane		21017		ISA	iuy:
	tems terms	Funerai	11. Marital Status	Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ Black, White,	
920	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23e or 28e-f ehow event, the Medical Exercions ruist by multiled at	by F	1 Never Married 2 Married 3XXWidowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Wh	
2-0036	72 ho	eted	15. Decedent's Educa (Specify only highest grade		edent's Usual Occupation re kind of work done during most of wor	king 16b	. Kind of Business/Inc	
12	within ane. then	Completed	Elementary/Secondary (0·12)	College (1-4or 5+)	DO NOT use retired)		T:	
Maryland 2121	m = 0 =	Be Co	17. Father's Name (First, Middle, Last)	ACC	20untant 18. Mother's Nan	ne (First, Middle, Maid	Financial den Sumame)	
ylar	Mental I	ToE	John Bennett		Lucill	e Unknown		
Mar	d 2 sh th and 7 ie m traum		19a. Informant's Name/Relationship (Type		ling Address (Street and Number or Ru			Code)
	s 1 an f Heal item 2 other		William M. Doyle 20a. Method of Disposition	20b. Place of Disp	G Sage Lane, Bel position (Name of ematory or other place)		27017 Location - City or To	wn, State
Ē	Page ment o ant: if ury or		1 X Burial 2 □ Cremation 3 □ Read 4 □ Donation 5 □ Other (Specify)	noval nom State		6-2006 Ne	w Castle.	Delaware
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 ie marked eny injury or other traumatic es ARCB.		21. Signature of Funeral Service Licensee		22. Name and Address of Facility R . 111 S. Queen $St.$,	T. Foard F	uneral Hon	ne, P.A.
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. Do not el cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	, mo 21,	Approximate Interval Between
j.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Dementio	2 advance	9		Onset and Death
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XOR	death certificate be ettending physic of for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of delive	ry Dav Year
Ö.	t the de	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	Other (specify)			
<u>,</u>	w requires thet the de been signed by the s should be detached	þ	Part II. Other significant conditions contri	buting to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to th	
000	v requi	ompieted				1 Tes	2 DNO 3 Proba	
ě	hes hes ge 2	omp				24a. Was an autopsy performed	? death?	osy findings available inpletion of cause of
<u>E</u>	sicien: Th certificate irector, pag	BeC	25. Was case referred to medical examiner?		26. Place of D. a	1 ☐ Yes 2 ☐	No 1 □ Yes	21.5 No
5	ding Physicien: h. After this certific funeral director,	၉	1 ☐ Yes 2 ☐ No Hos	pital: 1 Inpatient 2 ER/Outpatie 28a. Date of Injury 28b. Time		ome 5 Residence)
VISION	ding After	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
<u> </u>	if or Attendi efter death. I Director: A d in by the fu	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St.	and Number or Rural	Route Number,
2	Hospital of the self	O	29a, Certifier 1 Certifying Physic	ian: To the heat of multiplication do				
	To the Hospital or Attenwithin 24 hours effer deal To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Examine one)	c: On the basis of examination and/or in and manner stated	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause red at the time, date a	e(s) and manner as sta and place, and due to	the cause(s)
,	To t To ti	Σ	29b. Signature and title of certifier	1 200	29c. License number	29d. [Date signed (Month, L	Day, Year)
•			30. Name and address of person who domi	pleted cause of death (Item 23a) (Type	Print) D 17182	Sc	ptember	- 22,200
	8		Maruel M - Co	RZAGL MP	J Law ST	veet 10.	Lorvde	en
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 5 20	32. Registrar's Signature	god /	YIMA	<i>≥</i> (<i>00</i>)	

State of Maryland / Department of Health and Mental Hygieney 31757 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day DONALD **EVANS** 2erl 1300 PTEM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hos 9. Birthplace (State or Foreign MARCE Lone C. Lower If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth JAN Pay, Year) **Funeral** Months Days 1⊠M 2□F Hours Min. NEW YORK 24 Director 064-66-3472 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Mudical Examiner must be notified at Yes 2 □ No GAITHERSBURG MD MONTGOMERY Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 20879 18535 BOYSENBERRY DRIVE # 317 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 X Never Married 2 Married 1 ☐ Yes 2 🗙 No 9 Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 🕅 No þ tf Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CUSTOMER SERVICE REP. PRIVATE 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOIS J ANDERSON DONALD EVANS JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 is sny Injury or other trau DONALD EVANS JR/FATHER 11313 DEMMY WAY CLINTON, MARYLAND 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 9/22/2006 CLINTON, MARYLAND 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lost only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 11 earl /Medical Due to (or as a consequence of): Examiner motor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in titated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the detached Ö 9 Unknown 9 Unknown Records, P. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s autopsy performed? 1 ☐ Yes 28 No 1 🗌 Yes of Vital 2 100 Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1- Yes 2 □ No 1. Inpatient 2 ER/Outpatient 3 DOA this the funeral of 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred To Al Van 3 Division 5 Pending that struck near of 1 Natural Injury death. 1 Yes 2 No 2 Accident investigation Truck sctor: 2006 0165 AN Kad 3 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by after Dirs 4 / Homicide within 24 hours aft To the Funeral Di completely filled in Hospital More box Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Atos 31. Date filed (Month, Day, Year) B2. Registrar's Signature State 5 Registrar 2006

Physicism Physic				1 - For State Registrar	State of N	l arylan		artmen			and M	-	giene Reg. No. (006	31758
### Finley # Elliott Family Finley Finley Elliott Sept. 22 2006 56:45 A* A Family Have prior embrous, you parse are number) 51 E. Creen Street 51 E. Creen Street 51 E. Creen Street 51 E. Creen Street 52 A* 52 A* 52 A* 52 A* 52 A* 52 A* 53), Last)							2. Date of De	ath	000	01700
State Second Second Second Second Second Second Second Se				Willard	Finley	F1	lliott						,		
Source Control Contr								4b. City.	Town, or	Location o	f Death	Sept.			
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Decided Physician Decided De		Euporal				lge (In yrs. I	last birthday)		1 Year		24 Hrs.	8. Date of Bir	th		nplace (State or Foreign
Unant Handelens of December 100. Close				234-03-0760				Months	Days	Hours	Min.	(Month, Da	y, Year)	Col	intry)
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The property of the property o		ylan how		10a. State 10b. County		10c. City	y, Town or Lo	cation		_					10d. Inside City Limits
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Physician Medical Examiner Physician Medical Examiner Sequentially is conditional and operations of the physical physi	ary	should have		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Rurai	Route Number	er, City or To	own, State, Z	ip Code)
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Physician Medical Examiner The State Physician Medical Examiner Physi				4 2 2 2	/4	ad the death	Do not ent	er the mode	e of duine	ZI.	N. Se	econd S	rroet	akland	
PRIVISICIAN Middled Reason or condition and resulting in death) Sequentially list conditions, fairly, leading to amending cause. Girls for as a consequence of): Due to (or as				shock, of heart failure. List of	only one cause on each	line.	i. Do not ont	or trie mode	o or aying	y, such as t	Jai Giac Oi	respiratory a	irest,		Interval Between
Sequentially list conditions cause. Effort Inderlying Cause (Disease of Injury 1 resulting in death) Last Part				disease or condition				car	dio	vasc	ular	r dise	ease		yrs
The content of the				,											
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The state of the s	Ħ	ian: rtifica stor,								26. Place	of Death				20.10
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1, per doc 8860 10-6-06 vt.

		Registrar 1. Decedent's Name (First, Middle, Last)	-		rtificate			2. Date of Death	J. No.		3. Time of Death
Physici /Medic		HOMER E.	FRALE	∠ Homer	E. Fr	aley		Month	O S I	Year	9:20A
Examin		4a. Facility Name (If not institution, give	street and number))	4b. City, To	wn, or Locatio	n of Death	,	4c. County	-	,
		WMHS-BrAC	KOCK C	AMPUS	Cur	nberl	ang		Alle	26A	ny
Funeral		5. Social Security Number 6. Sex	7. Age (]M 2□F	In yrs. last birthday, Q7 Yrs.		ear If Und ays Hours		8. Date of Birth (Month, Day,)	rear)	Cou	place (State or Fore
Director		Usual Residence of Decedent		87 Yrs.				02/05/19	919	Keys	er, WV
Mon		10a. State 10b. County	1	Oc. City, Town or L	ocation						10d. Inside City Lim
Ξ	ţċ	WV Miner	al	Key	ser						1 ☐ Yes 2][1
or 28	Director	10e. Street and Number			10f. Zip Co	ede		10	g. Citizen of V	What Cou	ntry?
23a	ai	Rt. 1, Box 213			26	6726				USA	
it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	Funeral		12. Was Decedent Event Armed Forces?	er in U.S. 13.	Was Decedent If Yes, specify	t of Hispanic (Cuban, Mexic	Origin? (Spe can, Puerto P	cify Yes or No- Rican, etc.)		e - Ameri ck, White,	can Indian, etc.
- N		1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give		1 ☐ Yes 2 🛣	No Speci	fy:		Specify		
ture!	Completed by	15. Decedent's Edu	Year or Dates: V		dent's Usual C	ecupation		1 1	6b. Kind of B		ite
Asolic	plet	(Specify only highest grade	completed)	(Give	kind of work of DO NOT use r	lone durina m	ost of workir	ng .	oo. King or or	usii 1933/11	ioustry
r the	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Inspect	tor			Ra	ilro	ad
h and Mental Hygiene. 7 is marked other than "r trsumatic svant, the Med	Bec	17. Father's Name (First, Middle, Last)				18. Mo	ther's Name	(First, Middle, Mi	aiden Surnan	ne)	
Menta irked itic s	To	Claude R. Frale	У			I	Bessie	V. Hoff	man		
and is made		19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Maili	ng Address (S	treet and Nun	ber or Aura	Route Number,	City or Town,	State, Zij	c Code)
ealth m 27 ner tr		Edna M. Fraley/ W	ife		1, Box				26726		
or off		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State		matory`or othe	r place)	0ct	. 2	Oc. Location -	City or To	own, State
lant:		4 ☐ Donation 5 ☐ Other (Specify)		Potomac N				006	Keyse	r, WV	7
Department of Health a Important: if item 27 is any injury or other tra		21. Signature of Funeral Service License	L. T.	11	2. Name and A	25 BT 277	Dill	ith Fune Keyser,		me 2672	6
		23a. Part1. Enter the disease, or compli	cations that caused th					-		20,2	Approximate
ysician		shock, or heart failure. List only or Immediate Cause (Final	^	71001	PNIE	mon	Lin				Onset and Death
Aedical		disease or condition resulting in death)	ASPIRA Due to (or as a c		11466	711101	11/-		·	-	2 Weel
aminer			-	CEREBR	Al	BLEE	D				3 week
-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c		1,00						
physicien and the burial-translt	Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
cien a urial-	Ě	resuming in death) cast	Due to (or as a c	onsequence of):							
hysic the b	dicai										
attending p	Me	IF FEMALE:	20 16	200-0							
attenc for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth 2 (Fetal death 3	Ectopic pregr					te of deliventh	ery Day Year
the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne or death 5	Other (special	(y)					
igned by the be detached	된	Part II. Other significant conditions con	tributing to death but r	not resulting in the u	inderlying caus	e given in Pai	rt I.	23e. Did toba	cco use cont	ribute to t	he cause of death?
ngis I	d by	HYPERNAT	-					1 ☐ Yes	2 □ No	3 Prot	bably 4 🔯 Unkno
been si should	ete							24a. Was an	24h)	Mara auto	opsy findings availa
page 2	Completed							autopsy performe	ed?	prior to co death?	impletion of cause
certificate rector, pag		25. Was case referred to medical				ac Di-	as of Dooth	Check only one	No 1	1 🗌 Yes	2□ No
s cer direct	To Be	examiner?	ospital:	2 ER/Outpatie	nt 3 DOA	Other		ne 5 🗆 Residen	ce 6 ∏Oth	er (Specii	(v)
ter th		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time o		Injury at Work?		8d. Describe how			
deetn. ctor: Af y the fur	atic	1 Natural 5 Pending investigation	(Mona, Bay)	out/ injury	M	1 Yes 2	□No				
recto	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, st	reet, factory, of	ffice	2	8f. Location (Stre		er or Rur	al Route Number,
rain rain ledir											
within 24 nours area deem. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Examin	sician: To the best of a ner: On the basis of ex	ny knawledge, déal camination and/or in	hionourrad at t	he time, data my opinion, d	and plans, a eath occurre	nd die to the rau d at the time, dat	se(s) and his	and due to	itated. o the cause(s)
the I	Med	oney	and manner state	1.							
₹ ° 8	-	29b. Signature and title of certifier	om.	D.	5ac. F	icense numbe	311 8		d. Date signer		,
		Misasa			_ <u>_</u>	006	2115	5 0	7-2	8-	2006
	- 1	30. Name and address of person who co	mpleted cause of deal								
9		WIRASAT HASN	AIN 90	O CETAL	J DP	Calms	ED!	AND, r	PIN	ICA	9

State of Maryland / Department of Health and Mental Hygien () 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Year 10:30 AM FRYMYER LEE 09 7 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Garrett Oakland

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Garrett County Mem'1 Hospital 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year) 01/28/1950 Birthplace (State or Foreign Country)

WV 5. Social Security Number **Funeral** 1 XM 2 ☐ F 56 233-80-1920 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Tucker Parsons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RR HC 64 Box 131 26287 USA filed within 72 hours after death a Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other than College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Important: If Item 27 is marked other tt any injury or other traumatic event, that once. laborer construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Willard Frymyer Rosetta Belle Beckett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 70 Box 191 Davis, WV 26260 Martha Ann Frymyer/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 □ Donation 5 □ Other (Specify) Parsons, WV Zion Cemetery 9/30/06 21. Signature of Funeral Service Licensee Hinkle Funeral Home, Inc. P.O. Box 186 Davis, WV 26260 y. Scott Approximate
Interval Between
Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDINE INFARCTION WITH CARDIOGONIC /Medical Due to (or as a consequence of): Examiner ATUSMOSCIONOSIS - Gomonacizon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and I be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 05077 Aconous Liver Prons COPD Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 23 € 3 ☐ Probably 4 Munknown been sig 1 ☐ Yes 2 ☐ No INCISIONAL HORNIA ROPALA 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ELBETUS has autopsy performed? res 2.23No 25, 2006 1 Yes To the Hospital or Attending Physician: : After this certifical funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Ampatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ۵ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a
To the Funeral C
completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 151564 MT Coll 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 21550 255 N. 4 TH ST STO Z DAKLARD MID 140R ZAKALUZNY, MD haste 32 Registrar's Signature 31. Date filed (Month, Day, Year) OCT 0 5 2006 State A STATE OF Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAmend#20b.Per FH PGC 9-22-06 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 17, CAROLYN L. FRANKLIN 4:21 Sept. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges' Hospital Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/31/1941 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 □ M 2√2 F 65 Yrs. Director 572-68-2405 Tennessee Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r then "neturel", or Iteme 23a or 28a-f ehow the Muzical Examiner must be notified at XXYes 2□No Funeral Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1182 46th Place, S.E. 20019 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 □ Yes ANNo If Yes, Give Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mentat Hygiene. em 27 te marked other then Elementary/Secondary (0-12) College (1-4or 5+) Housewife Self 12th traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Levi Smith Carrie Williams ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husband Item 27 other tra Reginald E. Franklin 1182 46th Place, S.E. WDC 20019 20b. Place of Disposition (Name of Competer), crematory ocentre place | Date | 20c. Location - City or Town, State | Competery, crematory ocentre place | Date | 20c. Location - City or Town, State | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | Competer | 20a. Method of Disposition Pages ō = 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny Injury or 4 ☐ Donation 5 ☐ Other (Specify) of Juneral Service 22. Name and Address of Facility 5801 Cleveland Avenue Riverdale, MD 20737/Freeman Funeral Svc s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. 23a. Part 1. Enjer the disease, or complic shock, or heart lailure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final tatal ardiac Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Box 68760 USB as t ettending f IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the e P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ stor: After this certificete has been sign the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes Division of Vital 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ▼ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🕱 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide • Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 3001

DHMH 17 Rev 1/2001

State Registrar 31. Date liled (Mgrin, Day, Year)

2006

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND#17perFH9/22/06, BWW, McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 17, 2006 **Physician** 11:50A M Lucille T. Freeman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Morath, Days, Year) 7 17 19 20 Birthplace (State or Foreign Country)
 MO 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕅 F 489-20-5095 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural; or Iteme 23a or 28a-1 show eny injury or other treumatic event. The Madical Examinat must be notified at once. 10a. State 10b County None 1 Yes 2 No Director MO St Louis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6539 Devonshire 63109 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. White 1 Never Married 2 Married 21215-0036 1 Yes X No Specify: Be Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City of St Louis Alderwoman Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bernard ٩ Virginia Kober Bornard Scheve 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6539 Devonshire, St. Louis MO 63109 Eugene P. Freeman, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 Cremation 3 Memoval from State 9/22/06 National Cemetery Jefferson Barracks MO 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Futural Service Licens Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARPIOVASCYlar Physician Vears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine sicien and burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the ettending physician and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical ettending phys for use as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Donknown HEIMER 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 4 ER/Outpatient 3 DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident efter death Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours eff Funeral Di letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 17, 2006 D0030414 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HERRING Prince 18/01 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 22 2008 Registrar

DHMH 17 Rev 1/2001

Registrar

SEP

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250	hysici		Decedent's Name (First, Middle, Las Lorraine Louis						2. Date of Dea Month Septem		. žშე	3. Time of Death 9:09A
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City		Location of Dea	ith	4c. Cou	nty of Death Mary	
	ineral ector		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Unde Months	r 1 Year	If Under 24 Hr. Hours Min	s. 8. Date of Birt			place (State or Fore
he Maryland	28a-f ehow otified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland St. Mai 10e. Street and Number		ity, Town or Lo	chan	icsvi	11e			1	0d. tnside City Lim 1 ☐ Yes 2 📆 I
h with 1	23a or	al Dir	38680 Harrisburg	Ct.			0659			U S	of What Cour A	ntry?
1215-0036 within 72 hours after death with the Maryland	si, or itema : Examinar mu	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Xidowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 Yes 2 MNo If Yes, Give Year or Dates:		Was Dece If Yes, spe	cify Cuban	spanic Origin? (i, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	В	Race - Americ Black, White, cify:	
1215-0 within 72 ho	then natu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or5+)	16a. Dece (Give life. Homema	kind of wo DO NOT u	al Occupa ork done du se retired)	tion uring most of wo	orking	16b. Kind of	f Business/in	dustry
Maryland 21215-0036 nd 2 should be filled within 72 hours af	arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Harold Ball		110				me (First, Middle, Hotchkin			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	oorlant: if item 27 ie m 7 injury or other traum 28.		19a. Informant's Name/Relationship (T. Renee L. Wiles, 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service License	/daughter	38680 Place of Dispondentery, crein cryland	Hari esition (Na. matory or o Veter	risbu me of other place rans	rg Ct., Sep Cem. 2	Mechanic temper 9, 2006 insfield	sville 20c. Locatio Chelte	e, MD on-City or To enham,	20659 own, State MD
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ath certif	ned by the attending principle of the detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregn 1□Live birth 2□Feta 4□Pregnant at time of a 9□Unknown	aldeath 3□	Ectopic p. Other (sp					Date of delive	ery Day Year
Hecords, P. The law requires that	should be deta	by	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying o	cause giver	n in Part I.		bacco use co		ably 4 Unknow
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ysicia	directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	ıt 3□ D0			Home 5 Resid		Other /Specifi	4)
VISION OF Attending Physical Physical	funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury : Work?		28d. Describe h			·/
LIVISION OF VITAL tal or Attending Physician: 3 s after death.	lo the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Ptace of Injury - At h building, etc. (Speci	ome, farm, str	eet, factor	y, office		28f. Location (S City or Tow	treet and Nur n, State)	mber or Rura	l Route Number,
Hospital or 24 hours after	e Funer letely fills	edical	29a. Certifier Chack only one) Certifying Phy	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or in	occurred vestigation	at the time , in my opi	e, date and plac nion, death occ	e, and due to the durred at the time, d	ause(s) and late and place	manner as st e, and due to	ated. the cause(s)
To the within 2	сошо	Me	29b. Signature and title of Cartier	~		290	. License		2		ned (Month,	* '
			30. Name and address of pe n	ompleted cause of death (Item	n 23a) (Tvne	Print)	リナン	2509		9/2	106	,
			Meindert Smith,	12070 Old Line	e Cente		iite	100, Wa	ldorf, MI	20601	1	
R	Sta legistr		31. Date filed (Month, Day, Year) SEP 2 6 2	32 Registrar's Signa	C. A	arde)						

Ammended #26 Verbally, 9/29/06, DLB, St. Mary's Co Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 24, 2006 4c. County of Death Mary Lou Fields September 2006 1:38P /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 30, **Funeral** Days 1 □ M 2 🗓 F 58 Director November 1947 Washington, DC 577-70-6275 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits the Maryland 10a State 10b County show ral, or Items 23a or 28e-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Charles Directo Benedict 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7831 Creek Rd. 20612 USA Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other then "nature treumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hair Stylist Hair Salon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Weston Shelby Fones Lula Frances Jones 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a Gary B. Fields/Husband 7831 Mill Creek Rd., Benedict, MD 20612 Department of Health Important: If item 27 any injury or other ti once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans Cem. 20a. Method of Disposition September 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 28, 2006 Cheltenham, MD 22. Name and Address of Facility Frinsfield-Echols Funeral Home, 21. Signature of Funeral Service Licensee P.A., 30195 Three Notch Rd., Charlotte Hall, MD MO0641 Approximate 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician metatahi pancrani cance /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause pleases or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): physician al Box 68760, Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 🗌 Yes 1 ☐ Yes 2 ☐ No 2 110 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Posidence 6 Other (Specify) P 1 ☐ Yes 2 ☐ ₩6 M☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manger of Death Certification; After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State Registrar DHMH 17 Rev 1/2001

within 24 hours a To the Funerel (

Medical

29a, Certifier

29b. Signature and title of certifier

attens

Kenneth L. Abbot

110 Hospital Road

and manner stated.

2006 32. Ry distrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Sule 110

29c. License number

1)56024

29d. Date signed (Month, Day, Year)

September 25 2006

Prince Frederick MI)

State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 28, 2006 Gilbert 11:30am **Physician** Edel George /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Heartfields of Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year | Min. | Menth, Day, Year | Dec 30, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F 215-38-9936 92 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State ir than "naturel", or Items 23s or 28s-f show the Medical Examinar must be notified at Frederick 1 Yes 2 □ No Frederick Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ooke Court 21701 within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 No Specify White Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Air Force other than Colonel Hygiene. 4 pelij 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Importent: If Item 27 Ie marked othe eny injury or other treumatic event. 17. Father's Name (First, Middle, Last) Be Edel Gilbert Augusta Claude 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 811 Dunbrooke Court, Frederick, Maryland 21701 Mrs. Eleanor Gilbert, Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Smithsburg Crematory Sep 29, 2006 Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) of Funeral Service 21. Signatu 22. Name and Address of Basiford P.A. Funeral Home MO0706 106 East Church St, Frederic 231. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 106 East Church St, Frederick, Maryland 21701 Immediate Cause (Final disease or condition resulting in death) Days Physician Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE: P.O. Box 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by page 2 should be 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Senile Dementia peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Cerebral Vascular Accident has 1 Yes 2XNo After this certification funeral director, I or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical 8 Assited Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death.
If Director: Af
of in by the fur investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide within 24 hours af To the Funerel D completely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 28, 2006 D37197 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
Alan H. Rohrer, M.D., 15 West Seventh Street, Frederick, Maryland 21701 31. Date liled (Month, Day, Year) \$2. Registrar's Signature State OCT 0 5 2006 Registrar

		1 - For State Registrar		S	tate of	Marylar	nd / Depa <i>Cei</i>			ealth a Death	ind Me	_	giene	006	31	767
	sician edical	1. Decedent's Walter	Name (First, Middi	Perr	y	G	reen				1	Date of Dea Month	Day	200C	3. Time 3:5	of Death 6AM
Company of the Compan	niner	Memo	me (If not institution rial Hospi	tal				Cur	nberla				Alle	egany		
Funer Direct	_	5. Social Secur		6. Sex	2□ F	54 Age (In yrs.	. last birthday) Yrs.	Months	Days	If Under 2 Hours	Min.	Jan 20,	⁾ 1952	9. Bird	thplace (State	e or Foreigi
Maryland	tor	10a. State	10b. County Alle			10c. C	ity, Town or Lo								10d. Inside	City Limits es 🔏 🗆 No
h with the	Funeral Director	10e. Street and 24631	Number	Rd. S	E			10f. Z	p Code	1555			-	en of What Co	ountry?	
IOFE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If filew 271 is marked or hier then "natural", or items 23s or 28s-1 show or of noiner teaumatic event, the Madical Examinar must be notified at	by Funer		tus Married Ž⊟ Mar red 4 □ Divorced	ried	Was Deced Armed Ford 1 1 Yes 2 If Yes, Give Year or Da	2 □ No		Was Decilif Yes, sp	ocity Cuba	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		4. Race - Ame Black, Whit Specify: vVhi	e, etc.	
21215-0036 od within 72 hours aff giene. er then "natural", or er the Medical Exam.	Completed		15. Deceder Specify only highe Secondary (0-12) 12	st grade co		4or 5+)	16a. Dece (Give life. Genera	kind of w DO NOT	ork done d use retired	luring most)	of working			of Business ral Exc		1
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Ce, Mary 1 and 2 shot Health and N tem 27 is me		19a. Informan Gale C	t's Name/Relations Green	ship (Type,	Print) Wife	9	19b. Mailir 2463	ng Addres	s (Street a	nd Numbe Rd.	r or Rural SE	Route Number Oldtov	er, City or T	Town, State, M	Zip Code) D 21 5	55
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Baltimo permit. Pag Department important: I	OUCE	1//	of Funeral Service	-7	W	M	- 3	10	8 Virgi		enue:	Cumberl		MD 2150		
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nat the death certificate be executed by the attending physicien and etached for use as the burital-transit	lan/Medical	in the pas 1 ☐ Yes 9 ☐ Unkr			If yes, outc 1 □ Live bir 4 □ Pregna 9 □ Unknow	ome of pregn th 2 Pet nt at time of	nancy al death 3[death 5[Other (s						d. Date of del Month	Day	Year
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DIVISION To the Hospitel or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check on one)	/γ 2€ Medical	Examiner	on: To the bas	sis of examin	owledge, deatl ation and/or in	vestigatio	n, in my op	pinion, deat	d place, ar h occurred	at the time,	date and p	place, and due	to the cause	
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		9 7	1 - State Registrar 1. Decedent's Name (First, Middle, Last	State of Marylan		artment rtificate				, ,	2006	3 1 7 6 8
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	Examir			LAND HOSPITAL		CL	INTO					GEORGE'S
	Funeral Director		5. Social Security Number 6. Se 577-06-8820 Usual Residence of Decedent	7. Age (In yrs.	Yrs.	If Under 1 Months	Days	Hours	Min.	NOV . 11	ar) Co	thplace (State or Foreign ountry) SHINGTON, DC
	hours after death with the Maryland lurel', or Items 23e or 28e-f ehow of Everillief must be rollified at	Director	10a. State 10b. County MD PRINCE GE 10e. Street and Number		y, Town or Lo					10g.	Citizen of What Co	10d. Inside City Limits
	sath with	eral D	9911 CHURCHHILL I		0 10		2077		0.40		U.S.A.	
036	be filed within 72 hours after death watal Hygiers and all and then then and attention to the world the world to the world the	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decede f Yes, speci 1 ☐ Yes 2		spanic Origin n, Mexican, F Specify:	n? (Specit Puerto Ric	y Yes or No- ean, etc.)	14. Race - Ame Black, Whit	
Maryland 21215-0036	within 72 ho ene. then "natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)		(Give life. L	DO NOT use	done d retired)	uring most o			Kind of Business	/Industry
א פר	a filed v il Hygie other I	Be Co	12th 17. Father's Name (First, Middle, Last)		PR	OPERT		ECIAL] 18. Mother's		First, Middle, Maid	PRIVATE en Sumame)	
yıar		To B	HENRY GWATHMEY SR					JOSEI				
a)	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke eny injury or other traumatic once.		19a. Informant's Name/Relationship (T) MARIE A. GWATHMEY 20a. Method of Disposition 1 Serial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Othe) (Specify) 21. Signature of Funeral Service Lice	Y/WIFE temoval from State MD	9911 Place of Dispo emetery, cren VETERA	CHURCI sition (Name natory or oth	HHTL e of ner place METE	L DRIV	VE UP Date /26/2		BORO, MAR Location - City or HELTENHAN	YLAND 2077. Town, State
n E	80553	1 1	23a. Part1. Enter the disease, or compl	ications that caused the death						ANDOVER,	MARYLANI	20785 Approximate
()	Physician /Medical Examiner the priistransit The priistransit	dical Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of the consequence of t	uence of): IVE LU: uanca J): IC PAR(NG COI			CER			Interval Between Onset and Death
DOX O	death certific e attending p d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □Live birth 2 □ Feta 4 □ Pregnant at time of di 9 □ Unknown	I death 3	Ectopic pre					23d. Date of del Month	ivery Day Year
rds, P.	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions coa	ntributing to death but not resi	ulting in the ur	nderlying car	use give	n in Part I.		23e. Did tobacc	_	o the cause of death?
Hec	The law ete has b page 2 si	Completed	esterno en como en acomo en a						_	24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vital	Physician: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 👿	ER/Outpatien	t 3□ DOA	Other	~		5 Residence	6 ClOthor (See	av4.1
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	o afte o	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	v)					City or Town, Sta	ate)	ural Route Number,
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	within 2 To the compler	×	29b Signature and title of certifier	12.			License				Date signed (Mont	
_	(10)		30 Name and address of person who co			Print)	D427		n es es e		MARYLAND	
	Sta	te	JOSEPH RANDALI 31. Date filed (Month, Day, Year)	JR M.D. 610 2. Registrar's Signa		BRANCI	H AV	ENUE T	LEMPL	E HILLS,	MAKYLAND	20/48
	Registr		orn 9 5 2006	Bed . K	(Anda	a)						

			For	State of Ma	ryland /					nd Me		'/	uue	217	69
			State Registrar	al.		Ce	rtificate	or D	veatn	2	Date of Dea	Reg. New	000	3. Time o	f Death
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	Examin		4a Facility Name (If not institution, give	street and number)	tist	Ho	4b. City, T	Own, or L	Location of	Death	Pork		County of Death	Asov	rera
-	Funeral		5. Social Security Number 6. S		(In yrs. last		f Under 1	Year Days	If Under 24	4 Hrs. 8	Date of Birt		9. Birth	place (State	or Foreign
	Director		578-48-8475 Usual Residence of Decedent	M 2□F 69		Yrs.				A	ug. 17	, 19			
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	the Mi	Funeral Directo	Maryland Calvert 10e. Street and Number		NOI	rtn E	Beach 10f. Zip (Code				10g. Citiz	zen of What Cou	ntry?	
	3a or	0	9640 Seashell Cou	rt. Apt. 2	03			20	714				USA	F	
	death	ner	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decede	ent of His	panic Origi	in? (Specif Puerto Ric	fy Yes or No- can, etc.)	- 1	4. Race - Amer Black, White	can Indian, etc.	
38	hours after death with the Marylan tural', or items 23e or 28e-f show a Evantral most be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give Year or Dates:	0		1 Yes 2		Specify:				Specify:	White	
5-0036	e E	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	1	(Give	dent's Usual	k done du	uring most	of working		16b. Kir	nd of Business/li	ndustry	
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<u>0</u>	Hygi other	Be Co	17. Father's Name (First, Middle, Last)						18. Mother	's Name (i	First, Middle,	Maiden			
Maryland 21	0 0 0	To B	James Green							y Ujo			. T Ct- 1 7	- Co dol	
Mar	d 2 sho h and 7 is m traum		19a. Informant's Name/Relationship (Judith W. Green										rth Bea		20714
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altimore,	Pages nent of I int: If its ury or o		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				netéry			9-27-0	06	Davi	s, WV		
Balt	permit. Pages 1 and 2 should Department of Health and Menimportant: If item 27 is marke any injury or other traumatic.		21. Signature of Fungral Service (ic)	Lefran MO	0053		2. Name and untt F						ashingt aldorf,		604
3 %			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. I	Do not er	iter the mode	00		1. (respiratory a	rrest,	+	Approxim Interval B Onset and	etween
- Silbition	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Cardiac	- Aa	pes	T /1	114	scal	dia	int	TACC	Tim	1 W	eer
	Examiner		ſ	Due to (or as a		,	Bon	1 30						3 00	eho
	P H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	A -	nce of):								16	~ 5
	te be executed ysician and te burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Dia be		nce of):	1							J 9.	3
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Vital Records,	ne law require has been si ge 2 should b	Completed									24a. Was		24b. Were au prior to death?	topsy finding completion o	s available cause of
al	T ale		25. Was case referred to medical						26 Blace	of Death	1 Yes	20 No	1 ☐ Yes	2□ No	
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Division of	ding Phy I. After this funeral c		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	ry 2	8b. Time Injury	of 2	8c. Injury Work			Bd. Describe	how injur	y occurred		
isio	or Attending after death. Director: Atte in by the fune	ficati	2 Accident investigation 3 Suitcide 6 Could not to determine	28e. Place of Inju	ury - At hom	e, farm, s	M street, factory		Yes 2□ř				nd Number or Ru	ral Route N	umber,
Ö	tal or /	Certification:	4 Homicide	building, etc	c. (Specify)						City or To				
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	29a. Certifier (Check only one) Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examinatio	edge, dea n and/or	ath occurred investigation	at the tim , in my or	ne, date an pinion, dea	d place, ar th occurre	nd due to the d at the time	cause(s) , date and) and manner as d place, and due	stated. to the cause	ə(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	0 4	1 k		290	c. License	e number	77	10	29d. Da	te signed (Mont.	h, Pay, Year)
•			30. Name and address of person, who	completed sauce of d	HA T	JAN /Tun	Print)		114	1/	45		1120	106	
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	State of Maryland / Department of Health and Mental Hygien 2006	3	1	1	
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		•	1 - State Registrar		Cei	tificate	e of l	Death		Reg	. No.	0,,,,
		V _r	1. Decedent's Name (First, Middle, Last)						2.	Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Charles Micha	ael Gere	k				S	eptembe		06 3:00 a.m.
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City,	Town, or	Location of	Death		4c. County of De	
		13	18165 Point Lookou		to a bitabata 3	If Under		k Hal		5 (5)		Mary's
77	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	Van	Months	Days	Hours	Min.	Date of Birth (Month, Day, Y	'ear) (rthplace (State or Foreign Country)
	Director	1	449-76-4995 Usual Residence of Decedent	62					0	ct. 5,	1943 Ma	ryland
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Maried	cto	Maryland St. Mary	y's	P	ark H	la11					1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number			10f. Zip	Code			100	. Citizen of What C	Country?
	ath w 238		18165 Point Lookou				206				nited St	
	er de	Funeral	Tr. Maritar Otatas	2. Was Decedent Ever in U. Armed Forces?	.S. 13. \	Was Deced f Yes, spec	lent of Hi offy Cuba	ispanic Orig n, Mexican,	in? (Specify Puerto Ric	y Yes or No- an, etc.)	14. Race - Arr Black, Wh	
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215	within 7, ene. then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. l	DO NOT us	rk done d se retired	during most ()	of working			
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yla	should be ind Menta i marked umatic ev	2	Cyril Joseph Gerel		401 14 11		(0)				e Hammet	
Maryland 21215-0036	d 2 sho		19a. Informant's Name/Relationship (Type Sandra Marie Gerel			•					City or Town, State, Hall, MD	
	s 1 and 2 should be filed if Health and Mental Hyg Item 27 is marked othe other traumatic event,		20a. Method of Disposition		lace of Dispo emetery, cren				. Noau Date		c. Location - City of	
Baltimore,	m O		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		-			20.2	006 1		D1- MD
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B	Depa Impo any li		Edward N. Blansfie	d, Jr. M000								D 20650-0279
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	Examiner	_	Sequentially list conditions, b.									
	ed sit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uerice or):							
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Box	eath cer attendin for use		23b. was decedent pregnant	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pr	ennancy				23d. Date of d	· .
		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of d 9□Unknown		Other (sp					Month	Day Year
P.0	that the de ed by the d	Physician/	9 Unknown		states a la state a			- i- D-dl		22a Did taha	and the contribute	to the cause of death?
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of Vital Record	w requir been si should	ompieted										
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ior	Attending r death. ector: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 16ar)	Injury	М		Yes 2□N	lo			
Division	or Atte after de Directo i in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory	, office		28f	Location (Stre City or Town,		Pural Route Number,
	spital or Attenous after deal ours after deal less Director: filled in by the		<u>_</u>									
	5 t 1 5 6	edical	29a. Certifier (Check only one) Certifying Physical Examin	cien: To the best of my knoer: On the basis of examina and manner stated.	wledge, death tion and/or in	occurred a restigation,	at the tin , in my o _l	ne, date and pinion, death	d place, and h occurred	due to the cau at the time, dat	se(s) and manner e and place, and di	as stated. ue to the cause(s)
	To the Hos within 24 ho To the Fun completely	Med	29b. Signature and title of certifier	and mainter stated.		290	. License	e number		290	I. Date signed (Mo	nth, Day, Year)
	⊢ s ⊢ ŏ		b 12 219	bolone	-M 1	17	71	764	.19		9-29-	06
	V.		30. Name and address of person who con	npleted cause of death (Item	23a) (Type,	Print)			-			
	1/4		James P. Jarboe, M	1.D., 24035 T	hree N	otch	Road	, Ho1	lywoo	d, Marv	land 2063	36
10	Sta Registr		31. Date filed (Month, Day, Year)	32. Pegistrar's Signa		and I				,		
	negisti	21 6	KEP 7 W /U	UU/ EMPLOYED /								

			1 - For State of Registrar	•	artment of Health an rtificate of Death		iene 006	31771
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Deat Month	Day Year	3. Time of Death
	/Medic		George Wellington Gr				er 23,2006	9:39 P M
	Examin	er	4a. Facility Name (If not institution, give street and num	nber)	4b. City, Town, or Location of D		4c. County of Death	
	E		Bayside Care Center 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,	Lexington Par		St. Mar	nplace (State or Foreign
	Funeral Director		218-38-8816 ¹™ 2□F	66 Yrs.	Months Days Hours	Min. September	20,1940 Mary	and
	Pu .		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or L	conting			10d. Inside City Limits
	ehov	'n			ocation			1 ☐ Yes 2 🏋 No
	28e-f	Funeral Director	Maryland St. Mary's 10e. Street and Number	Hollywood	10f. Zip Code	1	0g. Citizen of What Co	
	aa or	ā	24621 Moran Road		20636		USA	,
	ms 2	nera		dent Ever in U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No-	14. Race - Ame	
9	or its	/Fu	1 ☐ Never Married 2 ☐ Married 1 XXYes If Yes Giv	2 No	1 ☐ Yes 2 No Specify:	dento Filoan, etc.)	Black, White	s, etc.
003	ureľ,	d b	3 X Widowed 4 Divorced Year or Di	ites:		1		Mite
21215-0036	within 72 hours after death with the Maryland ane. than "neturel", or liems 23a or 28e-f ehow the Madigal Evantiner must be notified at	Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation a kind of work done during most of DO NOT use retired)	working	16b. Kind of Business/l	ndustry
212	with iene.	шo	Elementary/Secondary (0-12) College (1	-40r 5+)	chanic		AC/Ref.	
b	al Hyg othe vent.	Bec	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle, M	Maiden Sumame)	
ylaı	Menta	Tof	Luke Manning Gray		Bertha	Theresa Brown	1	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or Items 23a or 28e-f show appringury or other treumatic event, the Medical Examinat must be notified at ance.		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Number o		i.	ip Code)
	1 and 1ealth om 27 ther t		Sharon L. Cooper / Daughter 20a. Method of Disposition	24613 20b. Place of Disp	B Moran Road, Hollyw		1 20636 20c. Location - City or "	Town State
סַר	ages or of h		1 X Burial 2 □ Cremation 3 □ Removal from	State Charles Me	matory of other place)	20. 2006		
Baltimore,	artme artme ortani injury		4 □Donation 5 □ Other (Specify) 21. Signalure of Funeral Service Licensee	Garde	115		Leonardtown, N	aryland
Ba	permi Depa Impo eny ir		Mail of Year Short		2. Name and Address of Facility Pattingley—Gardiner 2.0. Box 270, Leonar	Funeral Home,	P.A.	
10			23a. Part1. Enter the diseash, or complications that c shock, or heart failure. List only only cause on e					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Care				Onset and Death
	/Medical		resulting in death)	or as a ownsequence of):	· Cancar			- Jims
	Examiner		Sequentially list conditions, b.	Lune	Cancel			197
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence of),			U
	sicien and burial-transit	xan	that initiated events c. Due to (or as a consequence of):			1	
760,	ysicier e buri	calE	d					
68	es that the death certificate igned by the attending physi be detached for use es the							
Вох	th cer lendin r use	Physician/Med	230. Was decedent pregnant	come of pregnancy inth 2 Eetal death 3	☐Ectopic pregnancy		23d. Date of deli	
	e death he atten	sici		ant at time of death 5	Other (specify)		Month	Day Year
P.0	requires that the een signed by th nould be detache	Phy	Part II. Other significant conditions contributing to de	eath but not resulting in the	inderlying cause given in Part I	23e Did tol	pacco use contribute to	the cause of death?
ds,	signe d be c	1 by	Takin Only significant conditions contributing to de	agai bat not resulting in the	ardenying cause given in a late.	1 2 Ye		obably 4 Unknown
000	~ Q 76	ete				24a. Was a	n 24h Were au	topsy findings available
Records,	e la has	Completed				autops perforr	ned? prior to death?	completion of cause of
Vital	ician: Th certificate rector, pag	a l	25. Was case referred to medical		26 Place of	☐ Yes 2		2 No
S	\$ × 5	ToB	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ I	npatient 2 ER/Outpatie	Other		ence 6 Other (Spec	cify)
n of	ding Ph h. After th funeral	L:uc	27. Manner of Death 1 ■ Natural 5 □ Pending (Moni	of Injury h, Day Year) 28b. Time of Injury	of 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
Division	uttending death. ctor: After y the funer	Certification:	2 Accident Investigation		M 1 Yes 2 No			
Σ	or Ati	Ę	determined 286. Place	of Injury - At home, farm, s ng, etc. <i>(Specify)</i>	treet, factory, office	28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the	best of my knowledge dea	th occurred at the time, date and r	lace, and due to the co	ause(s) and manner as	stated
	e Hos 24 hi Fun etely	Medical	(Check only / 2 Medical Examiner: On the b.	asis of examination and/or interpretated.	nvestigation, in my opinion, death	occurred at the time, d	ate and place, and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	11	29c. License number		9d. Date signed (Monti	n, Day, Year)
	-		> Jamai Hin	109/11	1006	+19	9-25%	86
				e of death (Ite 23a) Type	* .			
					Hollywood, Marylan	1 20636		
	Sta Registi		31. Date filed (Month, Day, Year) 32. R	egistrar's Signature				

			For State Registrar	State of Ma	ryland		artment of H		and Men		giene	21116	31772
	D 1		1. Decedent's Name (First, Middle, La	ist)		*				Date of Dea	ith Day	/ Year	3. Time of Death
	Physici /Medic		BEATRICE MARY							eptemb	er	18, 200	
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of	of Death		4c.	County of Deal	th
			5022 55th Aven		/In vre la	st birthday)	Hyattsv: If Under 1 Year		24 Hrs. 9	Date of Birth	P	rince G	eorge's thplace (State or Foreign
	Funeral Director			1□M 2፟MF	83	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day 12/21/	192	2 Ver	mont
	D		Usual Residence of Decedent							,,			
	arylar ehow	_	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits 1 X Yes 2 □ No
	28a-1	Director	Maryland Prince (George's	Hya	ttsvi]	10f. Zip Code				10- 00	zen of What Co	
	with t						207	0 1					ountry /
	ns 23	Funeral	5022 55th Aven	12. Was Decedent E	ver in U.S	i. 13. V	Was Decedent of H		gin? (Specify	Yes or No-		5 • A • 14. Race - Ame	erican Indian,
20	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. in merked other than "natural", or Itema 23a or 28a-f show eumstic event, the Madical Examiner must be notified at		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💥 No	0				, Puerto Rica	in, etc.)		Black, Whit	e, etc.
903	iral', c	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1□Yes 2XINo	Specify:				Specify: W	White
<u>7</u>	"natu	Completed	15. Decedent's E (Specify only highest gr			(Give	tent's Usual Occup kind of work done	during most	of working		16b. Ki	nd of Business/	/Industry
2	within sne.	du	Elementary/Secondary (0-12)	College (1-4or 5-	+)		DO NOT use retire	•			D - 4	1 1	
d 2	Hygie Hygie other	e Co	17. Father's Name (First, Middle, Last)		SWIT	chboard	_	r's Name <i>(Fii</i>	rst, Middle,		lroad Sumame)	
_	m - 0 5	To B	Joseph Beaudoin	2					lyn Mo			,	
Maryland 21215-0036	permit. Pages 1 and 2 should be I Department of Heatth and Mental I Important: If Item 27 is marked of eny injury or other treumatic eve once.	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street				r, City o	r Town, State, 2	Zip Code)
Ξ	and 2 alth a		Ronald P. Henry	- Son		13506	Bottom	Road,	Mt. A	iry,	MD 2	21771	
ore.	of He of He fiten roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pla	ace of Dispo metery, cren	sition (Name of natory or other pla	сө)	Date		20c. Lo	cation - City or	Town, State
Ĕ	Pag ment ant: I ury o		4 □ Donation 5 □ Other (Speci		Fort		ln Cemeter		9/21/2				Maryland
Baltimore,	ermit. epart nport ny inj		21. Signature of Funeral Service Lice	nsee			. Name and Addre					-	
	40 = 9		23a. Part1. Enter the disease, or com	> 7013	79		39 Balti					le, MD	20781 Approximate
	Charle be executed by Medical Examiner by Medical St. the purial-transit	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any least of the cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Head and Due to (or as a b. Due to (or as a c. Due to (or as a	Necl conseque	ence of):	eer						Interval Between Onset and Death
9	tificat og phy as th	Medi											
C. Box	The law requires that the death certific site has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Petal €	death 3	Ectopic pregnanc Other (specify)	у			1	23d. Date of del Month	livery Day Year
ק	res that the de signed by the a be detached t	y Ph	Part II. Other significant conditions	contributing to death but	t not resul	ting in the ur	nderlying cause giv	en in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?
SD	puires n sign	d by								1 🗆 Y	es 2[□No 3□Pr	obably 4 Munknown
Hecords,	s been s been	Completed								24a. Was a	an	24b. Were au	utopsy findings available
e T	The lav	mo								autop: perfor	med?	death?	utopsy findings available completion of cause of
		0	25. Was case referred to medical					26. Place	of Death (CI		2∭ No ne)	10 103	2 140
>	Physics this ce al direc	To B	examiner? 1 ☐ Yes 2 ី No	Hospital: 1Inpatien	nt 2 🗆 E	R/Outpatien	t 3□ DOA Ott	ner: 4 □ Nur	rsing Home	5 🔀 Resid	ence (6 □Other (Spe	cify)
0 _	ding Ph h. After th funeral	ë	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	28c. Injui Wo	ry at	28d.	Describe h	ow injur	y occurred	
<u> </u>	uttendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2□N					
Division of	or A	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	ry - At hon . (Specify)	ne, farm, str	eet, factory, office			Location (S City or Tow			ural Route Number.
	Hospita 4 hours Funeral ely filled		(Check only 2 Medical Exa	nysician: To the best of miner: On the basis of	examination	rledge, death on and/or inv	n occurred at the til	me, date and	d place, and th occurred a	due to the o	ause(s)	and manner as	s stated. to the cause(s)
	To the within 2 To the complet	Medical	one) 29b. Signature and title of certifier	and manner stat	.00.		29c. Licens	se number		;	29d. Dat	e signed (Mont	h, Day, Year)
	F ≱ F 8		man	O Wel	tr.	v.	D237						9, 2006
Ω	(2)		30. Name and address of person who	completed cause of de	ath (Item :	23a) (Type					Jepe	CMDCL I	., 2000
_	(3)		Martin D. Weltz,	,	•		nter Dri	ve, #2	205. G:	reenbe	elt.	MD 207	70
	Sta		31. Date filed (Month, Day, Year)	2. Registra			w .'						
	Registr	ar	SEP 2 2 200	6 Leven	A	43704							

			for State Registrar	State of M	laryland		artmen rtificate			and M	•	giene,	0.00	31773
	Dhycisi	25	1. Decedent's Name (First, Middle, Las.)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medio		Jacob Aaron Huff								Sept	19	2006	21:07P M
	Examin	er	4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of			4c.	County of Death	1
			Washington Count 5. Social Security Number 6. Se		ll ge (in yrs. la	ast hirthday)	If Under	1 Year	Hage	rsto	WN 8. Date of Birt		Washing	ton County
	Funeral Director			X M 2□ F	3 0 ()	Yrs.	Months	Days	Hours 1	Min. 30	(Month, Da) Sept 1	y, Year)		nplace (State or Foreign untry) yland
	P .		Usual Residence of Decedent								Dept 1		OO Dai	
	anylar ehow	_	10a. State 10b. County		10c. City	, Town or Lo								10d. Inside City Limits 1 ☐ Yes X☐ No
	Ne M	Director	Maryland Washi	igton			Smith		rg			10= Chi	zen of What Cou	
	with t	2	10e. Street and Number 106 Joel Circle	2			10f. Zip		21783			rog. Citi	U.S.A.	antry :
	ns 23	Funeral	11, Marital Status	12. Was Deceden	t Ever in U.S	S. 13.	Was Deced			gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Amer	
9	ours after death with the Marylan rai', or itams 23a or 28a-f ehow Examiner must be notified at	큔	1 Never Married 2 ☐ Married	Armed Forces		+	lfYes,spec 1☐Yes		n, Mexican		Rican, etc.)		Black, White	white
93	72 hours after death with the Maryland natural', or Itama 23a or 28a-f ehow Jisal Examination to notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			10 105	201 140	зреспу.				Specify:	willce
5		ete	15. Decedent's Ed (Specify only highest grad	ication le completed)		16a. Dece (Give	dent's Usua kind of woi DO NOT us	al Occupa	ation during mosi	t of worki	ng	16b. Ki	nd of Business/I	ndustry
21215-0036	with sne.	Completed	Elementary/Secondary (0-12) N/A	College (1-4or	5+)	<i></i>	N/A	30 / 01// 00	,		1		N/A	
d	∰ ₹ £ £	BeC	17. Father's Name (First, Middle, Last)		•	·			18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)	
Maryland	o to to	To B	Jeffery B. Huff							N	lelissa	L. '	Tracey	
lar)	2 should and Mei is marke		19a. Informant's Name/Relationship (7										Town, State, Z.	
	2 2 2 2 2 2 2 2 2 2 2		Jeffery B. Huff	(father)	Took O						thsbur		ryland 2	
Baltimore,	6 0 2 2		20a. Method of Disposition 1 Disposition 2 Cremation 3	Removal from State	9	ace of Dispo emetery, crea							cation - City or 1	
Ħ.	교육관금 .		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funer II Service License		Ceda	ar Law					-2006			n Maryland
Ba	perm Depa Impo any i		21. Signature Puneril Service Closis	1. Haulh	1/		.331 E	laste	ern B	" Doι lvd.	igias A N. Hage	. Fig	ery Fune own Mary	eral Home yland 21742
	_		23a. Parti. Enter the disease, or comp	lications that cays	ed the death									Approximate Interval Between
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each		00 ()	18							Onset and Death
	/Medical		resulting in death)	aDue to (or a	s a consequ		10							
	Examiner		Sequentially list conditions,	·	SPI	rato	14	tai	lu	e				1
-	pe jist	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	ience of):	1	120	lu 105-	+				
	axecut al-trar	xan	that initiated events resulting in death) Last	c. Due to (or a	s a consequ	ience of):		11	()					
8760,	The law requires that the death certificate be executed site hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	calE		d										
.89	tificat ng phy as th	e d	1									- 1.	- 10	
Вох	eath certific ettending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth			∃Ectopic pr	egnancy				2	23d. Date of deli	very Day Year
E	at the dea by the et tached fo	Physician/M	1 Yes 2 No	4□Pregnant 9□Unknown	at time of de	ath 5	Other (sp	ecify)					WORLT	Day Todi
٩.	that the		Part II. Other significant conditions co	ntributing to death	but not resu	ılting in the u	nderlying c	ause give	en in Part I.		23e. Did to	obacco u	se contribute to	the cause of death?
ds	uires n sign ld be	d by									1 🗆 1	/es 2[⊒No 3□Pro	bably 4 Unknown
Records,	aw requir is been s 2 should	Completed									24a. Was		24b. Were au	topsy findings available
Re	The laviete hes	mo									autor perfo	rmed?/	death?	ompletion of cause of
Vital	ician: 1 certificel rector, p	Bec	25. Was case referred to medical examiner?						26. Place	of Death	Check only o			
of V	Physic this ce al dire	ပို	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpai		ER/Outpatier			4 🗆 140				Other (Spec	eify)
Ë	ding P h. After t funera	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Pay Year)	28b. Time o Injury	f 2	8c. Injun Work			28d. Describe I	now injur	y occurred	
Division	eat or:	lcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of la	niury - At ho	me farm st			Yes 2 🗆		28f. Location (S	Street an	d Number or Ru	ral Route Number,
Σ	- a = -	Certification;	4 Homicide determined	building,	etc. (Specily)	,,	, 000			City or Tov			
	To the Hospital of within 24 hours af To the Funers! D completely filled in		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the bes	it of my know	wledge, deat	h occurred	at the tin	ne, date an	id place,	and due to the	cause(s)	and manner as	stated.
	the Hin 24 the Fi	Medical	one)	and manner	stated.					un occur				
	with To	2	29b. Signature and title of certifier			MO	1		e number	08	_	29d. Dat	e signed (Month	n, Day, Year)
		151	y	ra/		140		100	57	800	×	09	120120	xxe
31	4-1	10	30, Name and a Press of person who d	omulate cause of	MONIO	2311) (Type,	Print)							
	Sta	te	31. Date filed (Month, Day, Year)				1 .1		-					
	Registi		SEP 252	006	was ,	ture B. D	serie	•						

State of Maryland / Department of Health and Mental Hygien 2006 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** SUSAN HOLT 9.15 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundale Anne ARUNDAUE Annapolis

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) medical Centen 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ▼ F 85 Yrs. May 19 Director 577-22-8739 1921 Maryland Usual Residence of Decedent death with the Manyland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, Ita Madical Examinat must be notified at once. 1 ☐ Yes 2√2 No Director Maryland Anne Arundel Lothian 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1324 B Marlboro Rd. 20711 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XXNo Specify: Black Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th 0 Nutritionist Andrews Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aaron Johnson Louise Chase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothea Smith(Daughter) 3365 Forest Rd. Waldorf, Md. 20601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 9-23-06 Drury, Md. Moses Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. Lavy 1. Leese MO0483 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIAC **Physician** HRRHXTHMI /Medical Due to (or as a consequence of) Examiner HTEROSCLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funsrel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit pertensi Due to (or as a consequence of): Records, P.O. Box 68760, Medical Certification; To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Monknown Dementio 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? Ange mi'a autopsy performed 1□ Yes 2 No 1 🗌 Yes 2 No Division of Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) - 50653 2006 ana 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C murt DEALE 32. Registr s Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** 25, 2006 6:15 p.n. September Lee Harman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hollywood
If Under 1 Year | If Under 24 H St. Mary's 25672 Sotterley Road 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) .Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. Yrs. 3, 1913 93 Maryland Director 717-07-6736 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location r then "naturel", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Maryland St. Mary's Hollywood Direct 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number United States 25672 Sotterley Road 20636 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2X Married White 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) other then Elementary/Secondary (0-12) Smithsonian Institute Operations Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe ery injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) Be Edna Meleive Donaldson Edward Lee Harman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25672 Sotterley Road, Hollywood, Maryland 20636 Elizabeth Harman / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Maryland Veterans Cem 10-2-2006 Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. uneral Service Licensee Edward N. Brinstreld. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed use as the burial-transit estive and resulting in death) Last Due to (of as a consequence of attending physician for use as the hurial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) pe 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No certificate director. Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 TER/Outpatient 3□ DOA this 28c. Injury at Work? funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: After Attending Injury 1 Natural 2 Accident 5 Pending 1 Tes 2 No death. investigation after death Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 0 within 24 hours a To the Funeral C To the Hospitei 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie H0055751 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt, D.O., 40900 Merchants Lane, Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 7 2006

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H rtificate of L			giene leg. No.	006	31777
ı	Dharaini	3	1. Decedent's Name (First, Middle, Las	st)					ith Day	Yeer	3. Time of Death
	Physici /Medio			Ann Hammet	t			Septemb	September 23,2006 10:55 P		
1	Examin	er	4a. Facility Name (If not institution, give	_			Location of Death			C+ Mox	
	*		St. Mary's Nursi 5. Social Security Number 6. S		(In yrs. last birthday)	Leonardt	OWN If Under 24 Hrs.	8. Date of Birt		St. Mar	place (State or Foreign
	Funeral Director			☐M 2【XF	67 Yrs.	Months Days	Hours Min.	May 10,	1939	Mary.	intal)
	A		Usuel Residence of Decedent								
	ırylan show	_	10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f s	Director	Maryland St. Mary'	S	Compton	1.2 - 2 .					
	with th	D L	10e. Street and Number	1		10f. Zip Code 20627				en of What Cou ISA	ntry?
	eath	erai	40010 Ben Morgan Roa	12. Was Decedent E	ver in U.S. 13.	Was Decedent of Hi	spanic Origin? (Sc	ecify Yes or No-		4. Race - Ameri	ican Indian,
39	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f show sayl highry or other traumatic event. In Mexical Exactles must be recilied at ODGs.	by Funerai	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 💥 N If Yes, Give Year or Dates:	0	If Yes, specify Cuba 1 ☐ Yes 2 █ No	Specify:	Rican, etc.)		Black, White, Specify: White	, etc.
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2	ithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+) life.	DO NOT use retired)	9	Own 1	Uomo	
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anc	ntal hed of	Be	Warren James Guy					ances Whe		orname)	
Ž	should nd Me mark matic	ဥ	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street a				Town, State, Zi	ip Code)
Z	nd 2 state are trau		Spencer Jerome Hamme		P.O.	Box 164, Co	mpton, Mar	yland 206	27		
Baltimore, Maryland 21215-0036	ages 1 au nt of Hea :: If item		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆		20b. Place of Dispo cemetery, cre St. Francis	matory or other place		Date ember 2006		ation - City or T	
	ertme ortani Injury		4 □Donation 5 □Other (Specify 21. Signature) of Funeral Service Licer	4	Cenie	tery					Leilu
B	Depermination of the services once	k II	Thicke He	n. Had	ner I	Name and Address Mattingley—(O. Box 27(ardiner fü , Leonardt	neral Homo own, Mary	land 2	.0650	
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	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a	a consequence of):	0					
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	ficate be executed physician and is the burial-transit	Examin	Cause (Diseese or injury that initiated events resulting in death) Last	C. Due to (or as a	a consequence of):					-	
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P.O. Box	the death certificate be executed y the attending physician and ched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 N No 9 ☐ Unknown	23c. If yes, outcome of the control	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23	3d. Date of deliv Month	very Day Year
	law requires thet the de as been signed by the a 2 should be detached t	þ	Part II. Dther significant conditions of		23e. Did tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown						
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Division of Vital Records,	The ate h page	Completed			1.804			24a. Was autop perfo 1 \(\text{Yes} \)		24b. Were autoprior to codeath?	opsy findings available ompletion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Dea				
of	Phys this rat dir	٠. ح	1 Yes 2 No 27. Manner of Death	1 Inpatier		nt 3 DOA	4 Nursing H	ome 5 Resident			(fy)
O	ding th. After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Work	k? Yes 2 □ No		, , , , ,		
Visi	Attending at death.	Certification:	3 Suicide 6 Could not b	Α	iry - At home, farm, st	reet, factory, office		28f. Location (S City or Tox	Street and	Number or Rui	rai Route Number,
ā	rs after or rs after all Dir		Tiomode	Duliding, etc	(Эрвспу)				vii, Olalo)		
/ \	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ledical	29a. Certifier (Check only one) Medical Example 14 Certifying Ph	nysician: To the best on the basis of and manner sta	examination and/or in	th occurred at the time rvestigation, in my op	ne, date and place, pinion, death occu	and due to the rred at the time,	cause(s) a date and p	ind manner as solace, and due	stated. to the cause(s)
	within To th compl	Σ	29b. Signature and title of certifier	m 1 to	w	29c. License	1428		29d. Date	signed (Month)	Day, Year)
			30. Name and address of person who		eath (Item 23a) (Type	*		1		<u></u>	
	dia C		Dr. William D. Boyd, 31. Date filed (Month, Day, Year)		oint Lookout ur's Signature	koad, Leona	aratown, Ma	ryland 20	050		
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511	0.41.47 Day 46										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician September 19, 2006 2:51 P Burger Iden Vane /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Garrett Garrett County Memorial Hospital Oak land 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1**X** M 2□ F Yrs 82 235-34-0984 July 9, 1924 West Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10b. County 28a-f ahow directions be notified at 1 ☐ Yes 2 ☑ No Director 0akland Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 21550 IISA 789 Penn Point Road death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. or itama 11 Marital Status filed within 72 hours after 1 ☐ Never Married 2 X Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White the Medical Exar ģ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) than . College (1-4or 5+) Elementary/Secondary (0-12) 12 Telephone Company Engineer 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if itam 27 is marked oth any injury or other traumatic event <u>suce</u>. Be Tden Hazel Burger Ershel Wade 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 789 Penn Point Road, Oakland, Maryland Freda Iden/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 9/22/2006 Oakland, Maryland Garrett Co. Mem. Gds. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 32 S. Second St. Stewart Funeral Home Oakland, Maryland 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 Minutes **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, physicien Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day be detached for 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2**X** No 1 Yes Division of Vital Medicai Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel **Certifying Physician: To the best of my knowledge death occurred at the time date and place, and due to the nause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 19a. Curtifica (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9/20/06 D27205

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 2 2 2006

Dr. Karl Schwalm, MD



311 N. Fourth St., Oakland, Maryland

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year Physician 23,2006 4:15AM SEPTEMBER ALLEN BENNETT JACKSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GENESIS LA PLATA CENTER CHARLES TA PLATA Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 10XM 2□F 55 Yrs. 220-62-9421 Director OCT.5,1950 MARYLAND Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location worde. 10b. County ir than "neturel", or iteme 23a or 28a-f ehov tre Medical Examinar must be notified at No 2 No Director LA PLATA MARYLAND CHARLES 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 6325 FENNELL PLACE, APT.10 20646 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "netural; or ite other traumatic event. If a Mudical Essential. 1X Never Married 2 ☐ Married 1 ☐ Yes 2√ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: WHITE Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 CUSTODIAN ROY ROGERS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၉ FRANCIS VICTOR JACKSON MARY BEATRICE STINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5000 WOODUILL CT., CRESTWOOD, KY of Disposition (Name of Disposition (Na ALTHEA P. HOWELL-SISTER 40014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 XXBurial 2 Cremation 3 Removal from State = 5 permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) HOLY GHOST CH. CEM. 9-27-06 ISSUE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysici<u>an</u> ANCEK 27 KMOWTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown څ s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 🗌 Yes 2□ No 1 ☐ Yes 2 ZNO Division of Vital or Attending Physician: After this certification 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending after death.
I Director: Afted in by the fun 1 ☐ Yes 2 - No investigation 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours after To the Funerel Dire 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatore and title of certifier ne and address of person who completed cause of death (Item 23a) (Type, Print) 62 ATHEN EN 15 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 5 2006 Registrar

			For State Registrar	State of Mar		artment of H		lental Hygier	2006	31780			
			Decedent's Name (First, Middle, La	ist)				2. Date of Death	of Death 3. Time of Death				
	Physici /Medic		DOROTHY VIRGI	NIA JOHNS	ON			SEPTEMA	Eptember 23 2006 22				
	Examin		4a. Facility Name (If not institution, gir	re street and number)		4b. City, Town, or	Location of Death		h				
			WASHINGTON COUN				HAGERSTOW If Under 24 Hrs.			INGTON			
	Funeral Director			I□M 2IXIE	'In yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea	ar) Co	hplace (State or Foreign untry)			
			Usual Residence of Decedent	8)			SEPT. 11,	1921 WE	ST VIRGINIA			
	how		10a. State 10b. County	1	Oc. City, Town or L	ocation				10d. Inside City Limits			
	Ba-f e	cto	MARYLAND WASHIN	GTON		SHARPS	BURG			1 ☐ Yes 2 ☑ No			
	with th	Dire	10e. Street and Number	DV DOAD		10f. Zip Code	700	10g.	Citizen of What Co				
	eath v	erai	2834 HARPERS FER	RY KOAD 12. Was Decedent Ev	erin U.S. 13		782	acify Yes or No-	U.S. I				
	hours after death with the Maryland ture!, or Iteme 23s or 28s-f show al Exacting must be notified at	Funeral Director	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of H If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, White				
2-0036	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 😾 No	Specify:		Specify:	HITE			
2	72 h	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deci	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of works	16b. Kind of Business/Industry					
21	be filed within 72 hours after death with the Marylar tall Hygiene. All Hygiene. All Cother than "naturel", or lieme 23a or 28a-f show other than "naturel", or lieme 23a or 28a-f show avent, to Macilcal Examinar must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ollege (1-4or 5+)		()			A A III THE A COUNTY IN THE			
2	filed Hygie Hygie other I		17. Father's Name (First, Middle, Las)	F	SSEMBLER	18. Mother's Name	A.I. (First, Middle, Maid		ANUFACTURE			
au		To Be	HARRY E. MARTIN				HATTIE V	TRGINIA M	IRGINIA MANSFIELD				
Maryland 21	should and Men is marke	-	19a. Informant's Name/Relationship	Type, Print)	19b. Mai	ing Address (Street		I Route Number, Cit		Zip Code)			
	rt 2 ad		JUSTIN L. JOHNSO	N/SPOUSE	2834	HARPERS	FERRY ROA	D, SHARPS	BURG, MA	XYLAND 21782			
altimore,	Pages 1 ar		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 [Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place		Date 20c.	. Location - City or	Town, State			
Ē	tant:		4 □ Donation 5 □ Other (Spec	N)						MARYLAND			
Bal	permit. Pages Department of Important: If II eny Injury or o		21. Signature of Fundral Service Ce	Paul M		2. Name and Address BAST FUNER		7606 old					
			23a, Part1, Enter the disease, or cen	blications that caused the	ne death. Do not er	nter the mode of dvin	g, such as cardiac o	Boonsboro or respiratory arrest.	, Marylar	Approximate			
	Dhusisian		23a. Paht i. Enter the disease, by complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Acvite ale victoria Levice will a week										
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	oremi	Levi	ke mia		L Weeks			
	Examiner			_									
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	icate be executed physician and s the buriel-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
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ŏ	eath certifi ettending j I for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		41.000-00-0			23d. Date of del	ivery			
Ď.	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as	by Physician/Me	in the past 12 munths? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at tir		∐Ectopic pregnancy □ Other (s <i>pecify)</i>			Month	Day Year			
J.	res that the de signed by the i be detached	hys	9 Unknown	9L Unknown									
	es this	by F	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause give	en in Part I.			the cause of death?			
ord	w require been sig should b	ted						1 ☐ Yes	2 4¶0 3 ☐ Pr	obably 4 Unknown			
Records,	e law hesb	Completed						24a. Was an autopsy performed	prior to	topsy findings available completion of cause of			
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Vital	sicie: certil	o Be	25. Was case referred to medical examiner? 1 Yes 2 Yes	Hospital:	2 ER/Outpatie	ent 3 DOA Oth	Ar .	Check only one	6 🗆 Osbas (Cas				
ō	g Phys er this eral di	\mathbf{H}	27. Many r of Death	28a. Date of Injury (Month, Day)				me 5 Residence 28d. Describe how in		JIIY)			
<u>0</u>	Attending Physicien: ir death. ector: After this certific by the funeral director,	atlo	t ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation		<i>(ear)</i> Injury		Yes 2 □ No						
Division of	r Atte	Certification:	3 Suicide 6 Could not lead to determine	286. Place of injury	- At home, farm, s (Specify)	treet, factory, office		28f. Location (Street City or Town, St	and Number or Ru ate)	ıral Route Number,			
	Hospital or 24 hours afte Funaral Dir tely filled in												
	To the Hospital or Attence within 24 hours after death To the Funaral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of ea and manner state	xamination and/or i	nvestigation, in my o	ne, date and place, pinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as and place, and due	to the cause(s)			
	vithin 24 hos To the Fur completely	Me	29b. Signature and title of certifier	10 1110 0	1 1	29c. License	e number	29d. I	Date signed (Mont	h, Day, Year)			
		()	Robert Bru	LMU Per	sonal this	sician	D 000	4359	Sen 2	4. 2002			
	1		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type	Print)	411/1	200765	Ist wir	271711			
21	1-15		31. Date filed (Month, Day, Year)	32. Begistrar	Signature	MLJI.	LOHOL	KJIUK	My Ell	1 +1/42			
	Sta Registr		APP C C	006 Sz. Asylstran	A A	1.115			4				
			-2. 202	Jour Maller	1 1. 14	JEARLY .							

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 2005

	-	1 - State Registrar			Certi	ficate of L	Death		Re	g. No.	-		
× = 1		1. Decedent's Name (First, Middle, Las	st)						Date of Death	Day	Year	3. Time of E	Death
Physicia /Medic	- 1	Joseph Jackson								12/1	7 2006	2300	М
Examin		4a. Facility Name (If not institution, give street and number)			4	4b. City, Town, or Location of Death				4c. County of Death			
	<i>3</i>	6114 Buckler				Cl	inten			Pr.	in ce	George	5
Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. last birti	A	If Under 1 Year Months Days	If Under 24 H Hours Mi		Sate of Birth Mo <i>nth, D</i> ay, /17/19		9. Birth Cou Indi		Foreign
Director		304-42-9965		02	rs.			0.5	/1//19	44	Indi	.ana	
and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Local	tion						10d. Inside City	/ Limits
Aarylan f ehow	5	MD Prince ('oorgo!s	Clinton								1 🐼 Yes	2 🗆 No
the h	Director	10e. Street and Number	eorge s	CITICOL		10f. Zip Code			10	og. Citizer	n of What Co	untry?	
with Be or	<u></u>	6114 Buckler Rd.				20735				S.A.		,	
hours after death with the Maryland hours after death with the Maryland ture!; or Items 23a or 28s-1 show at Exeminan must be notified at	Funerai	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Wa	s Decedent of Hi	spanic Origin?	(Specify	Yes or No-		Race - Amei		
r iter	교	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 28 Yes 2 ☐ N	0		es, specify Cubai		erto Rica	n, etc.)		Black, White		
urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1979	1 1]Yes 2. ∰ No	Specify:			Sp	pecify: Bla	ıck	
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d within 72 piene. ir then "naline Medic	du	Elementary/Secondary (0-12)	Coltege (1-4or 5-		life. DO	NOT use retired,)						1
filed w Hygier other th	S	12		Enf	orce	ment Of				enta			
be fill double of the contract H	Be	17. Father's Name (First, Middle, Last)					18. Mother's N			faiden Su	mame)		
should ind Men marke umatic	2	Lewis V. Jackson					Ruby Je						
2 sh and ie m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Marie Thomas-Jackson-Wife 6114 Buckler Rd. Clinton, MD 20735											
1 and 1 and 1 ealth 1 and 1 ealth 1 ther tr	-	20a. Method of Disposition	ias-Jacksoi	20b. Place of			Ru. OI	Date			tion - City or	Town, State	
Pages nent of int: If lib ury or o		1 Burial 2 Cremation 3 Removal from State											
rtant njury	-	4 Donation 5 Other (Specify) Cheltonham Cemetery 09/25/2006 Cheltonham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3831 Georgia Ave. NW											
permit. Pages 1 and 2 should be filed with Department of Health and Mental Hysiens. Important: If item 27 is marked other thereny injury or other traumatic event, the pages.		21. Signature of Political Service Eccel	11.			ney's F		Home					
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
30 N		shock, or heart failure. List only one cause on each line. Interval Between Onset and Death										een eath	
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ertificate be executed sing physicien and se as the burial-transit	ca	(d										
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. 0 0 0	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 □ F	ctopic pregnancy				230	d. Date of deli		
ed to	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of death 5 Other (specify)					Month		Month	Day Year	
that the de	Phy	9 Unknown							00				
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wale wale	ם							-	24a. Was ar autops	У	prior to d	itopsy findings a completion of ca	vailable use of
The law	S								perform 1 Tes 2	No	death?	2 🗆 No	
ysician: Th iis certiticete director, pag	Be	25. Was case referred to medical examiner?	Hospital:			2 DOA Othe	26. Ptace of E	Death (Ch	neck only on	θ)			
Phys this	7	1 Yes 2 No 27. Manner of Death	1 🗆 Inpatiei		ime of	3 DOX	4 Nursing		5 Reside		Other (Spec	cify)	
ding Ph h. Atter th	lo lo	1.☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) Ir	njury	28c. Injury Work	Yes 2□No	280.	Describe no	w intury c	CCUTTO		
deatl deatl ctor: y the	Ica	3 ☐ Suicide 6 ☐ Could not b	e Can Place of Injur	ırv - At home, fai	rm stree			28f.	Location (St	reet and h	Vumber or Ru	ural Route Numb	oer.
atter Direction	Certification:	4 Homicide determined	building, etc	. (Specify)	,	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town				
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To the Hospital or Attending Physician: The law requires that the death within 24 hours stater death within 24 hours stater death. Yo the Euneral Director: After this certificate has been signed by the attencompletely tilled in by the tuneral director, page 2 should be detached for u	ž	29b. Signature and title of certifier				29c. License	e number		25	9d. Date s	signed (Monti	h. Day, Year)	
4 4		Salvader	Spreto	20		Ho	0537	77		Sepi	Temb	V 19.20	200
•		30. Name and address of person who	completed cause of de	eath (Item 23a) (Туре, Рг	int)		,	,	-			
		SALVADOR Sylv	sten 300	=1 Hosp	Di to	al Dri	reg C	Love	17,	Ma	2/ Co	d	
Sta Registr		29b. Signature and title of certifier Advaku 30. Name and address of person who Signature 31. Date filed (Month, Day, Year) SEP 2 2 2	006 32 Registra	r's Signature	boar	le la	,		V /				
riceisti	वा ।	021 22 2	Elisabethio	1									

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Donneil Hollis Jones Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Y September 25, 2006 Jones 1406 hrs Hollis Medical Examiner Donnell 4b City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Brunswick Frederick 8 South Maple Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Country) M(), Director 214-76-8803 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Ob. County 'n Md Yes 2 No REUNSWICK Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygiene and I share and Jis marked other than "natural", or items 23a or 28a-f show and I frequential event, the Medical Examiner must be notified at once. FREDERICK Director 10g Citizen of What Country? 10e Street and Number South 21716 Maple USA 14. Race - American Indian, Black Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. Never Married 2 Married Yes Specify: BL ACC 1 Yes 2 No specify Divorced If Yes, Give Year ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 DISABLES AIT 10 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JONES MARIE JAMES HOLLIS TROTTER Be or other traumatic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2(70) 19a. Informant's Name/Relationship (Type, Print) 2 203 FROOKICK MD APT MARIE 1336 TANLY AVE MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a Method of Disposition crematory or other place) Cremation 3 Removal from State 2006 KUNNYSVDE, MD, Department o SUNNBSIDE UMC Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses a. 110 WEST SOUTH ST Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a Ethanol and burropion intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED AMENDED attending physician or use as the burial item#23a,27,28a-f,perME,g860, 10/20/06 TI Division of Vital Records, P.O. Box 68760. 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 ive birth Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? page certificate ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this 1 V Yes 2 ဥ 28d Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28h Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Natural Yes 2 No 5 Pending Fnd 9/25/2006 Fnd 1:55 pm 24 hours after death To the Funeral Director: unknown Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) South Maple Avenue Brunswick, 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide determined (Specify) found at home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier September 26, 2006 O.C.M.E pm 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner

State

Registrar

31. Date filed (Month, Day, Year

istrar's Signatur

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For Stete Registrer		State of Mar	yland / L	Departme Certifica				Reg. No.	2006	31785	
	Physicia /Medic		Decedent's Name	<i>(First, Middle, Las</i> GARRY	DEAN	JOHN	SON			2. Date of De Sept		, 2006	3. Time of Death 3:00P M	
	Examin				street and number)	Hospi			Location of Death			County of Death		
Ī	Funeral Director		5. Social Security Nu 218-66-9	ımber 6. Se		In yrs. last bit		er 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da Dec • 5			nplace (State or Foreign Intry) aryland	
	D		Usual Residence of 10a, State	Decedenl 10b. County	1	I0c. City, Tow	n or Location						10d. Inside City Limits	
	Maryl	tor	MD Montgomery Gaithersburg								1 ☐ Yes 2 ☐ No			
	n with the 23a or 286 ist be not	al Director	10e. Street and Num		one Drive		10f. 2	Zip Code	0886			zen of What Col	untry?	
220	4 within 72 hours after death with the Maryland iene. lene. I then "natural", or Items 23s or 28e-f show in Maryland at the mark penalitied at the Maryland at the mark penalitied at the Maryland at the Mary	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed	ed 2 € Married 4 □ Divorced	12. Was Decedeni Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			edent of Hi becify Cuba 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		14. Race - Amer Black, White Specify: B		
212-0036	within 72 ho ene. then "natur he wed cal	Completed	(Speci	15. Decedent's Edify only highest gra	lucation de completed) College (1-4or 5+)							6b. Kind of Business/Industry AeroFlex		
V	filed wit Hygien other the	Cou	12:	th			Engine	erın	g Speci 18. Mother's Nam		L	inesch	er	
yiand	d be ental	To Be	Laur		Johnson					ra Sel				
Mary	and and sum	-	19a. Informant's Na	me/Relationship (Type, Print) Wife				nd Number or Ru					
Σ ω	of Health Item 27		Sheree 1		Johnson					Gaith		burg, M.	D 20886	
Baitimore,	permit. Peges 1 and Department of Health Important: If Item 27 any Injury or other tr		t 🔀 Burial 2 [4 □ Donation	Cremation 3 5 Other (Specifi	Removal from State Gate of Heaven 9/25/06						Si	Silver Spring,MD Funeral Home, PA		
g	permit Depar Impor any In	_	21. Signature of Fu	non P	Lamo	6 8	246	N. W	ashingt	on St	Roc		, MD20850	
			23a. Part 1. Enter the disease, or complications that ceused line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										Interval Between	
	Physician /Medical		Immediate Cause (disease or condition resulting in death)	rinal n	Due Jo (or as a	CONSEQUENCE	of):							
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O. Box	The law requires that the death certifi ste has been signed by the ettending page 2 should be detached for use es	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant al time of death 5 Other (specify)						:	23d. Date of delivery Month Day Year		
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Division of Vital Records,	The law require te has been si, age 2 should t	Completed									psy	24b. Were autopsy findings available prior to completion of cause of death?		
ital		BeC	25. Was case refer	red to medical				100	26. Place of Dea					
n of \	Attending Physician: The indicator. The indicator. After this certificate has ector. After this certificate has by the funeral director, page.	lon; To	1 Tyes 2 27. Manner of Deat 1-Natural	h 5 Pending	Hospital: 1 Impatient 28a. Date of Injury (Month, Day	28b.	Time of Injury	28c. Injun Work	at	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
Divisio	irec Irec Irec	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Locat								tion (Street and Number or Rural Route Number, or Town, State)			
	To the Hospitel or At within 24 hours efter or To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)		ysicien: To the best of niner: On the basis of each manner state	examination a								
)	To the comple	Me	29b. Signature and	itle of certifier	2			29c. License	les 7	1	29d. Da	te signed (Manti	n, Day, Year)	
•	10				completed cause of dea			1 Dat	hords	MD 200	217			
	Sta Regist	ate rar	31. Date filed (Mon	th, Day, Year)	MD 10215 32. Jegistrar	rernw 's Signature	Sperte	Det	hesda,	THD 200	<u>, </u>			

State of Maryland / Department of Health and Mental Hygiene,

Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last)

MoNicA - JAYA SINGH 2. Date of Death 3. Time of Death Suplember Year **Physician** 00-12A M 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Howard County General Hospital Columbia Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 15, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 20 F India Yrs. 217-43-7015 88 1918 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 4600 Willowgrove Drive 21042 or itama 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specif Asian þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home or other traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked oth any injury or other traumatic avent once. Be <u>William Rama Rao</u> Dhamayanti Anandsingh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sundari Doraiswamy/ Daughter 4600 Willowgrove Drive, Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Sept. 23, 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John's Cemetery Ellicott City, Maryland 2006 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION day /Medical Due to (or as a consequence of): Examiner HYPERTENSION Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner led by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Non- INSULIN DEPENDANT DIABETES 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed OSTEO ARTHRITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 212 No 1 Yes 2 No 25. Was case referred to medical examinar? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funerel Director: After ti completely filled in by the funera 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of confirier 29d. Date signed (Month, Day, Year) NB September 20, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N.B. VELLANKI, 8850, COLUMBIA, 100 KM KWAY; # Zo8

DHMH 17 Rev 1/2001

State

Registrar

N.B. VELLANKI,

31. Date filed (Month, Day, Year)

SEP 21

5008

1 - For State Registrar

32. Adjistrar's Signature

COLUMBIA.

MD.

21045

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Caroline A. Kowalski 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day September 26, 2006 1000 hrs Caroline Ann Kowalski Medical Examine 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Worcester Ocean City 169 Jamestown Rd Apt 503 If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Foreign Months Davs Hours Director August 18,1935 Country) New Jersey 71 145-26-1934 1 M 2**X** F Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 No 28a-f show Ocean City Worcester notified at once. MD. death with the Maryland Director 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number Apt 503 21842 USA 169 Jamestown Rd. items 23a 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 1 X Yes Specify White rmit. Pages 1 and 2 should be filed within 72 hours after a parament of Health and Montal Hygiene, opportant: If item 27 is marked other than "natural", o jury or other traumatic event, the <u>Medical Examiner n</u> If Yes, Give Year 1954-1956 4 Divorced 1 Yes 2 No specify: ģ 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Law Baltimore, MD 21215-0036 Secretary 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Catherine Curran Manley Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 169 Jamestown Rd., Apt. 503, Ocean City, MD 21842 Stanley H. Kowalski - husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 09-28-06 1 Burial 2 X Cremation 3 Removal from State Alexandria, VA. Metropolitan Crematory Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Maryland 20715 23a. Part I. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) tran and Physician/Medical X UNPENDED **AMENDED** item#23a,27,perME,g860, 10/25/06 TT attending physician for use as the burial P.O. Box 68760 23d Date of delivery IF FEMALE 3b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? certificate has performed? page 2 ✓ Yes 2 No 1 🗸 Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: funeral director, of Vital Be Other₄ examiner? Nursing Home 5 Residence 6 Other Scene 2 ER/Outpatient 3 DOA Inpatient this 2 1 🗸 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural Division 1 Yes 2 No 5 Pending Funeral Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be 3 Suicide or Town, State) determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe September 27, 2006 O.C.M.E. ne and address of person who completed o death (Item 23a)

State

Registrar

Theodore M. King, Jr., MD

0°6°2006

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

a comment

			1 - For State Ragistrar	State of M	Maryland / Dep <i>Ce</i>	artment of F			giene Reg. No. 0	06 31788		
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å	Physici /Medic	_	Sharon R.	Kelly					ber 25,			
1	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o		Death	4c. County			
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1	Funeral		5. Social Security Number 6. S 213–54–3706	ex □M 2(X)F	Age (In yrs. last birthday) 57 Yrs.	Months Days	Hours	Min. 8. Date of Bird (Month, Da May 31	y, Year)	Country)		
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Maryland 21215-0036	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street	and Number	r or Rural Route Numb	er, City or Town,	State, Zip Code)		
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if Item 27 is marked other than "natural", or Itams 23a or 28a-1 show important if Item 27 is marked other than "natural", or Itams 23a or 28a-1 show important or other traumatic event, I're Medical Examinar must be notified at Once.		21. Signature of Funeral Service Licer	orine.	(FP 5	22. Name and Addre Olloway F Ol Snow H	uneral ill Ro	Home P.A. J. Salisbur	y, Maryl	land 21804		
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	R		30. Name and address of person who									
	-		Dr. Doug Mitche		Ol Medical	Pkwy, Ann	apolis	s, MD 21403	5			
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Division of Vital Records, P.O. Box	The law requires that the death certify the has been signed by the attending tage? should be detached for use a	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1□Live birth 4□Pregnant a 9□Unknown	2 Feta	al death 3	Ectopic Other (s	pregnancy specify)					23d. Date Mor			/ear
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	the H iin 24 the F iplete	Medical	5.107	miner: On the basis and manner s	tated.	ation and/or in	restigatio	ят, птту ор	milion, deal	us occurr	ou at the time,	uate and	расе, а	na aue t	ine cause(s	1
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•	(5)		30. Name and address of person who				,						1			
	0		DR. PASMA CI				7600	Carı	:011	Aven	ue, Tak	oma	Park	, MI	20912	<u>}</u>
	Sta Registr		31. Date filed (Month, Day, Year) SFD 2 2 2006	82. Regist	rars Signa	ature-	7									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** SEPTEMBER 20,2006 JUNE KINNA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kline Hospice House Mount Frederick Airy If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Yrs. Director 219-12-1004 84 June 13, 1922 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r then "neturel", or iteme 23a or 28a-f ehow the Medical Extrainer must be notified at 1 X Yes 2 ☐ No Director Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 West Fifth St. 21201 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 own home 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Heelth and Mental Hy Important: If item 27 is marked oth any liquy or other traumatic event once. 17. Father's Name (First, Middle, Last) Harry Allen Carrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave. / Hagerstown, MD 21704 17806 Virginia Kelly Burdette Farris / Dght. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 09/25/2006 Frederick, Maryland 4 ☐Donation 5 ☐ Other (Specify) 01ivet 21. Signature of Funeral Service Licepsee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part. The rithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shows heart failure. List only one cause on each line. Immedia Cause (Final disease or condition resulting in death) metastatic Presumed Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events weeks Due to (or as a consequence of): Examiner before deats To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physicien and d be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? themia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown should I 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 200 No 1 TYes Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOUSE Hospital: ٥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death 28b. Time of 28c. Injury at Work? Certification: Naturat 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours efter death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0056786. 30. Name and address of person who complete of death (Item 23a) (Type, Print) Frederick. Suite Kidge 31. Date filed (Month, Day, Year) SEP 2 egistrar's Signature State Registrar

Amended Item #5 per Funeral Director via SSA; 09/29/06 cs

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 9 2006 1:15 A.M Anna Mae Kidwell /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street end number) Examiner WMHS -Sacred Heart

5. Social Security Number
220-34-1566
230-34-1566
Usuel Residence 9. Birthplace (Stete or Foreign Country) Cumberland MD Hospital If Under 1 Year 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Yeer) **Funeral** Months Days Hours Min. 79 Director MD 4-11-1927 Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No Director MD Alleq. Westernport 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21562 USA 220 Greene ST Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2V No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: White δ 3 ₩idowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Extension Serv. Elementary/Secondary (0-12) College (1-4or 5+) Univ. of MD 12 Nutrition Aide 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel M. Peer Arthur V. Pope 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15 E. Railroad St Lonaconing, MD 21539 Francis E. Kidwell -Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Peter's Cemetery 9-25-06 Westernport, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fredlock Funeral Home -31 Jones St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. 26750 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Criscon Examiner Due to (or as a consequence Physician/Medical Examiner ettending physician end for use es the bunel-transit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 → Unknown 1 ☐ Yee 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 ☐ Yes 2☐ No this : After this funeral c 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 27. Menner of Deeth 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending ours efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Plece of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours e To the Funeral C completely filled Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

h

To the

29a. Certifier

29b. Signature and title of certifier

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

Jesus Tan Broadway St. Frostburg, MD.21532

Registrar

31. Date filed (Month, Day, Year) 32. Registrer's Signature SEP 2006

29c. License number

29d. Date signed (Month, Dey, Year)

		- State Registrar			Cei	rtifical	e or	Deain	1 -	Reg. No.		6	0117
Physici	an	1. Decedent's Name (First, Middle, Last) Valerie L. Kartma	n						2. Date of De Month	Day		ear	3. Time of Death
/Medio		4a. Facility Name (If not institution, give si				4b. City	Town o	r Location of Deal	Septemb		County of	-	2040
Examin	ier	PONINSULA REGIONAL	MASICAL	NET	red		4	4 / /shi/M	<u>_</u>		Hicon	•	
Funeral		5. Social Security Number 6. Sex	7. Age		st birthday)	If Unde	r 1 Year Days	If Under 24 Hrs Hours Min		irth	9	Birthpla	ace (State or Fore
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r 28a-f show	Director	10e. Street and Number		DCII		10f. Zi	Code	-		10g. Cit	izen of Wha	at Count	ry?
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Ē	Funeral		2. Was Decedent E Armed Forces?	Ever in U.S	3. 13.	Was Dece	dent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or N	0-	14. Race -	America White, e	
ē		1 Never Married 2 Married	1 ☐ Yes 2 🕱N	10				Specify:	to moan, etc.)		Specify:		hite
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disal Ex	Completed	15. Decedent's Educ (Specify only highest grade			16a. Dece (Give	dent's Usu	al Occup	pation during most of wo d)	rking	16b. K	ind of Busin	ness/Ind	ustry
2	m	Elementary/Secondary (0-12)	College (1-4or 5	+)		emake		5)			Own Ho	ome	
T,		17. Father's Name (First, Middle, Last)						18. Mother's Na	me (First, Middle	e, Maiden	Sumame)		
0	To Be	Roman Thill						Edna	Claus				
item 27 is marked other then other treumatic event, the M.		19a. Informant's Name/Relationship (Typ	oe, Print)		19b. Maili	ng Addres	s (Street	and Number or R	ural Route Numi	ber, City o	or Town, St	ate, Zip	Code)
1		Kimberly Best			3160	Rose	of	Sharon R	d., Dur	ham,	N.C.	277	12
r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	amount from State	20b. Pla	ace of Dispo	osition (Na matory or	me of other place	сө)	Date	20c. Lo	ocation - Ci	ty or Tov	wn, State
o Aur	Ш	4 □ Donation 5 □ Other (Specify)	emovai irom State	Sun	set M	emori	al P	ark 9/	23/2006	Ве	erlin	, MD	
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		23a. Parl 1. Enter the disease, or complice shock, or hear failure. List only on							c or respiratory	arrest,			Approximate Interval Between Onset and Death
ian		Immediate Cause (Final disease or condition	KEM O	LRH	A610	- 5	TR	OKE					DAYS
ical ner		resulting in death)	Due to (or as	a consequ	ence of):								
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for use as	Physician/M	236. was decedent pregnant	3c. If yes, outcome 1□Live birth			⊒Ectopic p	regnancy	y			23d. Date of		ry Day Year
of be	SICE	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown			Other (s					MOUT		Day (Bai
etach	Phy	Part II. Other significant conditions con	tributing to death by	ut not rocu	Iting in the u	undorhina		on in Part I	23a Did	Itobacco	use contrib	ite to th	e cause of death?
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tor, page				-					1 ☐ Yes	2 🖬 No		Yes	2□ No
director, pag	Be	25. Was case referred to medical examiner?	ospital:	0 🗆 -	-D/O-44		Ott	26. Place of De	ath /Check only		0 DO#	·C	
GS.	. To	27. Manner of Death	28a. Date of Inju		ER/Outpatie 28b. Time o		28c. Injur Wor		28d. Describe)
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by ‡	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At hor	me, farm, st	reet, factor	y, office		28f. Location	(Street ar	nd Number	or Rura	Route Number,
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Ö	Σ	29b. Signature and title of certifier	W			29		se number	,		ite signed (
		I Show &	mo				00	062911	5	52/7	5 m 13 8	2	1,2006
		30. Name and address of person who co			00-1 CT	C							

Please Type or Print in Black Indelible Ink

Robert Duane Korb State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ September 27, 2006 2021 hrs Medical Examiner KORB 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Peninsula Regional Medical Center Salishury 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Foreign Months Days Director Country) MARYLAND 212-77-3601 1 X M 2 F AUGUST 23,200**6** 4 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 X Yes 2 No 28a-f show ; 23a or 28a-f show : notified at once. MARYLAND WICOMICO SALISBURY Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene 10e. Street and Number 10f Zin Code 10g Citizen of What Country? 1505 LAVALE TERRACE 21804 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Married 2 X No Yes Divorced f Yes, Give Year Yes 2 X No specify. WHITE 3 Widowed 4 Examiner ģ or Dates 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene
7 is marked other than "1
1 atic event, the Medical E Baltimore, MD 21215-0036 N/A N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KORB JR. JOCELYN GOSLEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ္ရ 19a. Informant's Name/Relationship (Type, Print) nt of Health and
t: If item 27 is
other traumat 1505 LAVALE TERRACE, SALISBURY, MARYLAND 21804 ROBERT D. KORB JR., FATHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition Date crematory or other place) X Burial 2 Cremation 3 Removal from State Department or Important: injury or other EVERGREEN CEMETERY 10/2/06 BERLIN, MARYLAND Denation 5 Other Specify 22. Name and Address of Facilit Signature of Funeral Service HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art I. Enter the disease or complications **Physician** Between Onset and ailure. List only one cause on each lip /Medical Death Sillen unexplained death in infancy Immediate Cause (Final disease Çxaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical X UNPENDED X AMENDED physician the burial -#1.23a.27.28a-f. e862, 12/5/06 TT _nerME. Box 68760, 23c. If ves. outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Live birth Month Day Year Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown signed by the Phy 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 1 🗸 Yes No 26.Place of Death (Check only one) 25. Was case referred to medical æ Hospital: 1 Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 After this ပ္ 1 Yes 2 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury (Month, Day, Year Certification: Natural Yes 2 No 5 Pending To the Funeral Director: Fnd 9/27/2006 unknown unknown 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1505 Lavale Terrace Salisbury, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide determined (Specify) residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d Date signed (Month, Day, Year) O.C.M.E. September 28, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31. Date filed (Mo Registrar's Signature

State

Registrar

O

3 2006

Physicia /Medic		1. Decedent's Name (First, Middle		•				2. Date of Deat		3. Time of Death
/Medic		Francis Carlton	Kefauver					Septen	Day Yea	ry 5:59
Examin	aı	4a. Facility Name (If not institution		r)		4b. City, Town, or	Location of Dea		4c. County of De	eath
LXuiiiii		Washington Count	tv Hospital			Hage	rstow	1	wash	inaton
Funeral		5. Social Security Number	6. Sex 7. /	ge (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year) 9. 8	Birthplace (State or Forei Country)
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"natural", or iteme 23a or 28e-f ehow isolical Examinar must be notified at	Funeral Director	Maryland Washing 10e. Street and Number	gton	Willi	Lamspo			14	Og. Citizen of What	
10 20	吉					10f. Zip Code			-	Country
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E F	un.	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces	:?	. 13. 1	f Yes, specify Cuba	in, Mexican, Pue	rto Rican, etc.)	Bfack, W	
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od other	a	17. Father's Name (First, Middle,	Last)		·		18. Mother's Na	ame (First, Middle, M	Maiden Surname)	
marked c	To B	Lester Markwood	Kefauver				Esther V	Jirginia K	irbv	
EE	-	19a. Informant's Name/Relations			19b. Mailir					a, Zip Code) 21795
27 l		Jean H. Kefauve:	r, wife	- 4	16505	Virgini	a Avenue	, Cottage	244, Wil	Lliamsport,
item 27 le other tre		20a. Method of Disposition		1 000	ce of Dispo	sition (Name of natory or other place	ا ام	Date	20c. Location - City	or Town, State
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Important: If any injury or once.	1	21. Signature of Funeral Service		llage						neral Home
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by the attending phy. tached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant 9□ Unknown	2 Fetal of at time of dea	death 3 ath 5	Ectopic pregnancy Other (specify)		22a Did tak	23d. Date of o Month	Day Year
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 06 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Paul Franklin Lambert 6:30 AM Sept. 30 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Gilchrist Center for Hospice Care | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 4, 1938 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F 68 Director 219-36-0115 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rthan "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1420 Armacost Road 21120 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Tavern permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Importent: If Item 27 is marked other th eny injury or other treumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul P. Lambert Emma Isabelle Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 250 Turner Crossing Rd., Parkton, MD 21120 Felicia Buckingham, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mt. Zion United 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. Freeland, MD 4 ☐ Donation 5 ☐ Other (Specify) Methodist Cemetery 2006 21. Signatur, of Funeral Service License 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. Weikal 2/ Neuvas 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physician and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No detached for Year Month Day 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 ≧No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an this certificate has autopsy performed? 1 Yes 2 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 105/1/ CE ဥ 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai (Check only one) Medi 29b. Signatyre and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0061199 KIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason Black, 6565 NOTTH Charles ST, Suite 209, Touson 31. Date filed (Month, Day, Year) 32. Pogistrar's Signature State OCT 0 6 2006 Registrar

			For State Registrar	State of Mar		artment of F		Mental Hy		16 3	1796
			Decedent's Name (First, Middle,	Last)				2. Date of De	eath	3. T	ime of Death
	Physici /Medio		THELMA	LEFTHICH				SEPT	• •	Year	: 30 PM
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	Director		225-24-5892	1 □ M 2 💢 F	85 Yrs.	Months Days	Hours Min.	(Month, D.	ay, Year)	Gountry)	lai
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	r dea	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of I	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	o- 14. Race Black	American Ind White, etc.	lian,
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	To the Hospital or Attending Physician: which 24 hours after deals at the families certifies To the Funatel Director. After this certifies completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of r aminer: On the basis of ex and manner state	xamination and/or in	ivestigation, in my o	pinion, death occu	rred at the time,	date and place, an	d due to the ca	
	To th withir To th comp	Me	29b. Signature and title of certifier		-	29c. Licens	e number		29d. Date signed (Month, Dey, Y	'ear)
			KX			Ds	1860		SEPT &	1, 200	6
0	(5)		30. Name and address of person wh	o completed cause of dea	th (Item 23a) (Type,	Print)	11 -				
			JONATHAN FIS 31. Date filed (Month, Day, Year)	H MO /07	Signatura	FA Drive	# 200	(OWA)	Ald Mo	21044	
	Sta Registr		SEP 2 5 2006	Boom &	th (Item 23a) (Type,						

		•	1 - For State Registrar	State of Maryland		artment of H			ene g. N2 0 0	6 31797
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	1	3. Time of Death
	Physici /Medio		KATHERINE H. LAZA					Septembe	er 16, 2	2006 5:45 p M
1	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or		th	4c. County of	
	Ermanal		St. Mary's Nursing 5. Social Security Number 6. Sex	-	st birthday)	Leonard If Under 1 Year	If Under 24 Hrs			fary s 9. Birthplace (State or Foreign
В	Funeral Director			M 21∏F 82	Yrs.	Months Days	Hours Min	. (Month, Day, 6/20/1		Country) Maryland
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	faryla et e	ō								1 X Yes 2 □ No
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	death	Funerai		12. Was Decedent Ever in U.S Armed Forces?	5. 13.		spanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race	- American Indian, , White, etc.
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	i	1 ☐ Yes 2 No	Specify:	,		White
5-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked ther then "naturel; or Iteme 23a or 28a-f show is marked other then "naturel; or Iteme 23a or 28a-f show eumatic event, It in Mudical Examinar count be conflicted at		3		16a. Dece	dent's Usual Decupa	ation	1	16b. Kind of Bus	
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Box (leath certifica ettending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar		_ /	1		23d. Date	of delivery
m .	ne death the ette hed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Mont	th Day Year
о. О	that the deed by the detached	Phy	9 Unknown		utaa ta maa			OO Did to		to the terminal of death?
Ś	ires tha signed I be de	۵	Part II. Other significant conditions con	ithbuting to death but not resu	iting in the u	nderlying cause give	en in Part I.			bute to the cause of death? 3 Probably 4 Unknown
Records,	w require been si should t	Completed	D	mentia				24a. Was ar		ere autopsy findings available
Re	The lav	дшо		minua_	-			autops	y pri ned? de	for to completion of cause of eath?
<u>a</u>	ilcien: T certificat rector, pa	0	25. Was case referred to medical			<u> </u>	26. Place of De	1 ☐ Yes 2 eath (Check only one		☐Yes 2☐ No
<u>=</u>	hysicien: nis certifica I director, p	To B	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 E	R/Outpatier	t 3□ DOA Othe	95	Home 5 ☐ Reside		r (Specify)
0	Attending Physicien: r death. ector: After this certifice by the funeral director; is		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe ho	w injury occurre	d
Division of Vital	ttendi death stor: /	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hor	ma farm at		Yes 2 □No	28f Location (St	reet and Number	r or Rural Route Number,
<u>></u>	i or Atten after deat Director: I in by the	Certification:	4 Homicide determined	building, etc. (Specify,)	eet, factory, office		City or Town		or ribrar roble worlder,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	sician: To the best of my knowner: On the basis of examinati	vledge, deatl	n occurred at the tim	ne, date and place	e, and due to the ca	use(s) and man	ner as stated.
	To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner stated.		29c. License				(Month, Day, Year)
)	7 × 5 8		De la la la la la la la la la la la la la	It lander	-111		10641	9 "	9-19	2-0/
^	6 /10		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type	Print)	0011	1	1 10	
V	1- (10)		James P. Jarboe, M	D 24035 Three	Note	-	lo11ywoo	d, Maryla	nd 2063	6
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signar	uro					
	Registi	(eli	SEP 2 2 2006	MANUEL A.	LOOM					

			for State Registrar	State of Marylar		rtment of H			ene 2006	31798
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici /Medic		William Edward L	ank				SEPTENNIE	Day Year 121,2006	0020M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death	1	4c. County of Death	1
			Peninsula legiona	I medical le	oter	Sali	Shury		Wicon	ico
	Funeral		Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10 25	Year) / C	nplace (State or Foreign untry)
	Director		219-46-2606	M 2□F 59	Yrs.			10 25	1946 MD	
	and *		Usual Residence of Decedent 10a, State 10b, County	10c. Ci	ly, Town or Loc	ation				10d. Inside City Limits
	Manyl f ehc	0	MD Wicomico	M-i	llards	Md				1 ☐ Yes 2 ☐ No
	28a-	rect	10e. Street and Number		LITATUS	10f. Zip Code		10	g. Citizen of What Co	untry?
	3a or	<u> </u>	36118 Timber Dr.			21874	+		USA	
	within 72 hours after death with the Maryland ane. than "naturel", or items 23e or 28e-f ehow the Mudical Ezant on must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U		Vas Decedent of Hi	spanic Origin? (S	pecify Yes or No-	14. Race - Amer	
9	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		Yes, specify Cuba		o Hican, etc.)	Black, White	
8	rel', c	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give The Year or Dates:	'	Lifes 25 No	Specify:		Specify: Wh	ite
5	72 h	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give I	ent's Usual Occupa kind of work done of	furing most of wor	king 1	6b. Kind of Business/I	ndustry
2	han han	Idu	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	•		C	6
7	lled v tygia her t		17. Father's Name (First, Middle, Last)	1	Maryı	and State		ne (First, Middle, M	Governm	ent
and	ntal H	Be	William Lank					Holloway	aiden Sumame)	
Ž	hould d Me mark mark	ပ္	19a. Informant's Name/Relationship (Ty)	no Print)	10h Mailin	a Address /Street			City or Town, State, Z	in Code)
∑	d2 s th an t7 is		Robin Lank (wif			•		Villards,		<i>ip</i> 0000)
ō,	1 an Heal tem 2		20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of			0c. Location - City or	Town, State
2	ages int of t: ff li y or c		1 Burial 2X Cremation 3 R	emoval from State		natory`or other place open Crem		3/2006	Frankford,	DE
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: if Item 27 is marked other than "naturel; or items 23a or 28a-1 ehow appring to other traumatic event, the Madical Exprings must be notified at once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Service License			-			Funeral	
B	Departiment on it		V WALLING	11/18				Berlin, M		nome
			23a. Part1. Enter the disease, or complishook, or heart failure. List only or	cations that caused the deal						Approximate
	Physician		Immediate Cause (Final	1 A D C.	w ÷ A					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consec	uence of):					
	Examiner		Out of the Park of	DIA	BET	ES				
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	uence of):					
	nd	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
8760,	oe ex	0	resulting in deathy cast	Due to (or as a consec	(uence of):					
87	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai								
9 ×	leath certific attending p	Physician/Me	IF FEMALE:	3c. If yes, outcome of pregna	ancy			-	004 0-1-44	K. 1.
Box	atten for u	lan	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of deli Month	Day Year
o	that the de led by the a detached f	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
σ.	that ned b	<u>a</u>	Part II. Other significant conditions con	tributing to death but not res	sulting in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds	w requires that been signed should be det	d by						1 <u>Y</u>	3 2 □ No 3 □ Pro	obably 4 Unknown
00	s bee	jet						24a. Was an	24b. Were au	topsy findings available completion of cause of
æ	The lav te has age 2	Completed						autopsy perform 1 Yes 2	ed? prior to death?	2 No
Ţ.	an: rtifica tor, p	BeC	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2		20110
>	ysici iis ce direc	ToE	examiner? 1 ☐ Yes 2 🔀 No	ospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Othe	er: 4 🗆 Nursing H	lome 5 Resider	nce 6 Other (Spec	cify)
0	Attending Physician: or death. ector: After this certifice by the funeral director; §	ü	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at c?	28d. Describe how	v injury occurred	
Sio	endi eath. or: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division of Vital Records,	or Att after d Direct I in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre fy)	et, factory, office		28f. Location (Streetly or Town,	eet and Number or Ru State)	ral Route Number,
	ospital hours a uneral E ly filled		29a, Certifier Certifying Phys	ician Tashahara at an la						
	I 4 II 0	edicai	(Check only 2 Medical Examinations)	nician: To the best of my knowner: On the basis of examination and manner stated.	ation and/or inv	estigation, in my or	oinion, death occu	rred at the time, da	use(s) and manner as te and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier)		29c. License	number	29	d. Date signed (Montt	n, Day, Year)
	r s r ö		1			D55	658		9/21/0	26
•			30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type. i	2:0			112/	Ψ
	BA 6		TRAINE ARENA	PENINGULACI	PRINCIPLE	SU POSNE.	400 Ems	IRAN SILERE	De Salisi	BLAY ND
	Sta		31. Date filed (Month, Day, Year) 200	Registrar's Sign	A.	and I				21863
	Registr	ar	SEL Y 2 TO	- July	1					

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William E

	Maryland	Phys /Me Exar
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department or result and wester hypered. Important in terms 23a or 28a-f ehow more content. If the 27 le marked or the thin "naturel, or them traumatic event, the Medical Execution must be notified at any injury or other traumatic event, the Medical Execution must be notified at
4	Phy /IV Exa	/sicia ledic amin
of Vital Records, P.O. Box 68760,	Physician: The law requires that the death certificate be executed	r this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit

			For State Registrar	olate of Maryle	•	rtificate of		nemai m	Reg. No		0:100
	3		1. Decedent's Name (First, Middle, Last)					2. Date of D	eath Da	y Year	3. Time of Death
	Physici /Medic		GERALD JUSE	PH LO	VICIL			09		3 2006	1908 PM
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Examin		4a. Facility Name (If not institution, give stre				or Location of Death			County of Death	1000
			UNION HOSP			ELKT		MD			COUNTY.
	Funeral Director		5. Social Security Number 6. Sex 142-62-9081	7. Age (In y	rs. last birthday) 63 Yrs.	If Under 1 Year Months Days		Jan. 6	ay, Year	943 North	lace (State or Foreign itry) Carolina
	P ,		Usual Residence of Decedent	100	City, Town or Lo						Od. Inside City Limits
	arylar ehow	-	10a. State 10b. County		•					1	1 ☐ Yes 2 ☐ No
	Ba-f	Director	Maryland Cecil	No	orth Eas		·		40 0	200	
	with t	ä	10e. Street and Number			10f. Zip Code				itizen of What Coun	
	eath	era	5215 Turkey Point 11. Marital Status 12.	Was Decedent Ever in	n U.S. 13. V	21901 Was Decedent of I	Hispanic Origin? (Sc	ecity Yes or N		ed State:	
10	r Itan	Funeral	1 Never Married 2 Married	Armed Forces? 15 Yes 2 No ff Yes, Give			Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, White,	
ဗ္ဗ	el', o	þ	3 ☐ Widowed 4 ☐ Divorced	ff Yes, Give Year or Dates Air	Force	1 ☐ Yes 2 X No	Specify:			Specify: Wh:	ite
21215-0036	within 72 hours after death with the Maryland ene. then "naturel" or Itams 23s or 28s-1 show the Medical Execution most be notified at	Completed	15. Decedent's Educat (Specify only highest grade of		(Give	dent's Usual Occu kind of work done	during most of work	ang	16b. F	Kind of Business/Inc	dustry
7	vithin ne. han a	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	od)				
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and	ntal hed of	Be							s, maragi	obmanie)	
aryland	should nd Men merke umatic	ဥ	William Grayson Lo		19b. Mailir	ng Address (Street	Beatric		ber City	or Town, State, Zin	Code)
₹	od 2 s lith an 27 le trau		Leslie A. Lovick /				oint Road				
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: if item 27 le marked other than "naturel", or Itams 23a or 28a-1 ehow any injury or other traumatic event, it a Medical Eventral remarke notified at once.		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of		Date	-	ocation - City or To	
Baltimore,	Pages nent of int: If it iry or o		1 ∑Burial 2 □ Cremation 3 □ Reπ 4 □ Donation _5 □ Other (Specify)			p Baptis		ember 2006	Ameri	lor North	h Carolina
ä	mit partmoorts oorts / inju		21. Signatur of Junity Service Lieusee	61	nurch (e	metery 2. Name and Addre	4		1	cal Home	ii Garorina
m	Depa Impo any is		MARGE		12	7 South					yland 2190
r			23. Part1. Enter the disease, on complica shock, or heart failure. List only one	tions that caused the d cause on each line.	eath. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		fmmediate Cause (Finaf disease or condition	Multie	YC Pm	Serida.	11.			6	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):)					
45	LXaIIIIIei	_	Sequentially fist conditions: b if any, leading to immediate	Due to (c as a cons	ncion	~					
	ed sit	ine	cause. Enter Underlying Cause (Disease or injury							מוני ומי	•
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68760,	sicier buria										
9	tificate be executed ig physicien and as the burial-transit	edic									
ŏ		M/M	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pre		Ectopic pregnanc				23d. Date of delive	ery
m	Attending Physicien: The law requires that the death cer reach. •ctor: Atter this certificate has been signed by the attendir by the funeral director, page 2 should be detached for use	by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of		Other (specify) _				Month	Day Year
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	res th		Part II. Other significant conditions contri						tobacco Yes 2	use contribute to th	abiy 4 \(\sum \sum \subseteq \text{Unknown}
000	w require been sl should l	eted	Ancume L	UI Seu	ie, h	yper)H	demie		1185 2	:	adiy 4 Edikilowii
ခ္တ	e law has b	Completed	Ancumue 20 Melabolie cei,	dosis, L	ypel	spider	nuer	24a. Was	s an opsy form # d?	24b. Were auto prior to con death?	psy findings available mpfetion of cause of
E F	n: The		Tohereo en	-d alic	shol c	aboure		1 Yes	-2√□ N		2 No
₹	siciar certif recto	Be	25. Was case referred to medical examiner?	pital:		_ 0	26. Place of Deather:			_/	
Division of Vital Records,	Physic this oral di	. To	1 Yes 2 No	28a. Date of Injury (Month, Day Year			her: 4 Nursing Ho	ome 5 ☐ Res 28d. Describe			<i>y)</i>
O	th. Afte	tlor	1 ☑Naturaf 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	r) fnjury	f 28c. lnju Wo M 1	rk?]Yes 2 □No				
<u>Nisi</u>	Atter	Hice	a Could not be	28e. Ptace of Injury - A	at home, farm, str	eet, factory, office				nd Number or Rura	I Route Number,
ā	s afte	Certification:	4 I Hornicide	building, etc. (Sp.	вспу)			City or To	JWII, Stat	6)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier Certifying Physic (Check only 2 Medical Examine)	On the basis of exam	knowledge, death	h occurred at the ti	me, date and place, opinion, death occur	and due to the	cause(s	s) and manner as st ad place, and due to	ated. the cause(s)
	thin 2 the on the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen				ate signed (Month,	
1	F ≥ F 8		Maria					7 60		1/23/0	_
	Aug		30. Name and address of person who com	oleted cause of death (Item 23a) (Tyne		06373	>0		112010	<u> </u>
,	クナーバー		NAMITA TULL IN	VION HOS			00, MT	D			
1	Sta		31. Date filed (Month, Day, Year) SEP 2 5 2006	39/ Registrar's Si							
	Registi	ar	OLI N 0 2000	Williams.	A ANDER						

			For State	State of Marylan		artment <i>rtificate</i>			nd Mental Hy	giene Reg. 200	16 3180	าก
	N 74.40		Registrar 1. Decedent's Name (First, Middle, Las	it)		tineate	OI D	Calli	2. Date of De	eath	3. Time of D	eath
	Physicia		Annie Inez						Septem	per 19, 2	2006 12:45	РМ
	/Medic Examin	_	4a. Facility Name (If not institution, give			4b. City, T	own, or Lo	ocation of		4c. County		
		1	St. Mary's Nursin				nardi		t Ura la a la la		Mary's	
	Funeral		5. Social Security Number 6. S	ex 7. Age (<i>In yr</i> s. 74		If Under 1 Months		Hours	Min. 8. Date of Bi (Month, D	av. Year)	9. Birthplace (State or) Country) Maryland	r-orei g n
	Director		217-28-1736 Usual Residence of Decedent	12	+				sept.	21, 1901		
	rylan show		10a. State 10b. County	10c. Cit	ty, Town or Lo						10d. Inside City	
	89-f s	cto	Maryland St. Ma	ry's	Lexir	igton F				10g. Citizen of V		
	with the or 2	D I	10e. Street and Number 45678 Summer Lane			10f. Zip C		20653		US	·	
	hours after death with the Maryland turet; or Items 23s or 28e-f show al Examir or must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	I.S. 13.	Was Decede			n? (Specify Yes or N Puerto Rican, etc.)		e - American Indian,	
٥	or Ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖔 No If Yes, Give		1 Yes, specif		Specify:	Puerto Rican, etc.)	Specify	ck, White, etc. v: White	
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	within 72 ene. than "nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	kind of work DO NOT use	k done dur e retired)	ring most o	of working	FOD. KING OF BO	isiness/maastry	
212	ad with rgiene. sr thar	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Homema	aker			Owr	n Home	
and	al Hygid al Hygid d other	Be C	17. Father's Name (First, Middle, Last)				1		s Name (First, Middle		10)	
	ould to	2	Leeland Adams		401 14 10		(0)		osalee Ato		State Tie Code)	
Mary	s 1 and 2 sh f Heelth and item 27 is m other treum		19a. Informant's Name/Relationship (John R. Lynch - H						or Rural Route Numi Lexington			
ē,	s 1 an I Heel Item 2 other	3	20a. Method of Disposition	20b. I	Place of Disponentery, cre	osition (Name	e of	,,,,,	Date		City or Town, State	
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Baltimore,	mit porte inju		21. Signature of Funeral Service Licer			2. Name and			3035	01d Wash	nington Rd	En-over 1
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10			23a. Part1. Enter the disease, or com shock, or heart faifure. List only	plications that caused the deal one cause on each line.	th. Do not en	ter the mode	of dxing,	such as ca	ardiac or respiratory	arrest,	Approximate Interval Between Onset and De	
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Care	Liac	- HN	Mys	hm	u .		musul	81
35.	Examiner			Due to (or as a consec	Musica off:	MANANI	Och	h	Sorote	2	minus	128
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of)	11	A				777000	
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Cor	ma	ryH)	WE	Sef 1	U2_		45	×
8760,	ate be executed hysician and the burial-transit		resulting in death) cast	Due to (or as a consec	quence ot):	l		Y			0	
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		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of c		□Ectopic pre □ Other (spe				Mo	onth Day Ye	ear
o.	at the de	Phys	9 Unknown		a daine in the s			in Don't	220 Did	tobacco use cont	tribute to the cause of de	ath?
Š	Attending Physician: The law requires that the redail. Geath. sctor: After this certificate has been signed by the tuneral director, pege 2 should be detached.	þ	Part fl. Other significant conditions of	contributing to death but not res	sutting in the i	underlying ca	iuse given	i in Part I.			3 Probably 4 □Ur	
Š	w require been sig should b	etec							24a. Wa	s an 24h	Were autopsy findings a	vailable
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<u>a</u>	yeician: The is certificate hi director, page	0	25. Was case referred to medical	41				26. Pface (of Death (Check only	- 6	1 ☐ Yes 2 ☐ No	
<u> </u>	nyeici nis cer i direc	To B	examiner? 1 🗌 Yes 2 (5) No] ER/Outpatie	ent 3 DO/	A Other	4 Nurs	sing Home 5 Re	sidence 6 🗆 Oth	ner (Specify)	
Division of Vital Records,	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		Bc. Injury a Work?			how injury occur	red	
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<u>></u>	after after Directory	ertif	4 ☐ Homicide determined	building, etc. (Speci		ileet, lactory,	, onice		City or T	own, State)		
_	To the Hospitel or Attending Ph within 24 hours atler death. To the Funerel Director: After th completely filled in by the funeral	aic		nysician: To the best of my kn								
	ths Ho in 24 ths Fu	Medical	one)	niner: On the basis of examin and manner stated.	ation and/or i				OCCURRO at the time			
	To To Com	2	29b. Signature and title o certifier	a d) / a la	~ 11	1 29c.	License	number	19	29d. Date signe	9 (Month, Day, Year)	
-			yam	ST JOUTE	m 220 m	Brien)		10 00	. (1-1	1-00	
(NB3		30. Name and address of person who Dr. James P. Jart				, Bea	an Me	d. Ctr	Hollywoo	d, MD 20636	
4	Sta		31. Date filed (Month, Day, Year)	32 egistrar's Sign	ature	hack .	,			<u></u>		
1830	Regist	rar	SFP 2 2	2006 Likeur.	10.	THE PERSON NAMED IN						

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Certificate of	Death	Re	g. No. UUb	31801
			1. Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death
	Physici /Medio		REBECCA MCI	DERMOTT				Septemb	er 27, 200	06 1:39 PM
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	th
			FREDERICK MEMOR			FREDE			FREDER	
п	Funeral		5. Social Security Number 6. S	Sex 7.Age I□M 2⊊IF	(In yrs. last birti	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 27,	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		463-04-9313 Usual Residence of Decedent	Λ	55 '			Sept.27,	, 1951 1	exas
	land w		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Man	후	Maryland Freder	ick	Myers	ville				11∑Yes 2 No
	or 284	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	ith wi	Funeral Director	801 Rocky Founta	in Drive		21773	3		USA	
	r dee	ne	11. Marital Status	12. Was Decedent 8 Armed Forces?		 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
36	s afte	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 ☑ No	Specify:		Specify: W]	nite
21215-0036	s within 72 hours after deeth with the Maryland jiene. r than "natural", or Iteme 23a or 28e-1 ehow the Medical Examinar must be rodified at	ed th	15. Decedent's E		16a.	Decedent's Usual Occu	pation	1	6b. Kind of Business	/Industry
15	n "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5		(Give kind of work done life. DO NOT use retire	during most of work d)	ring		,
212	T 12 L T	E	12	5+	Man	aging Consu	iltant		Oil Softwa	are
þ	be filed tal Hygie d other event, II	Bec	17. Father's Name (First, Middle, Last)				e (First, Middle, M		
<u>la</u>	ked b	P	George William	White			Laverne	Estell	e Pohlme	yer
Maryland	and and em		19a. Informant's Name/Relationship (** ' '		Mailing Address (Street				
-	alth alth er tr		George McDermot	t - husband		1 Rocky Fou	-			
Baltimore,	permit. Pages 1 and Department of He Important: If term eny injury or other sone.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	cemeter	Disposition (Name of crematory or other plath burg Cremat	ice)		Smithchus	r Town, State rg, Maryland
Ë	tmen tant:		4 □Donation 5 □ Other (Special	1	Shirths					
Bal	Depar Mpor mpor nny ir		21. Signalure of Juneral Service Line	900		22. Name and Address Ricketts F			lain Stree	
			23a. Part 1. Enter the disease, or com	ollo	the death. Do n	4				Approximate
			shock or neart failure. List only Immediate Cause (Final	one cause on each lin	10.			or reapmentary arro	31,	Interval Between Onset and Death
1	Physician /Medical	i	disease or condition resulting in death)	a		EMBOLISI	7			
	Examiner			Due to (or as	a consequence o	r):				
ı,		ē	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as:	в попявіднавлю з	t)-				
V	cuted nd ransit	Examiner	that initiated events	c						
0	e exe ien er urial-t		resulting in death) Last	Due to (or as	a consequence o	f):				
68760,	cate be executed physicien end the burial-transit	Medicai		_ d						_
~	entific ding p	-	IF FEMALE:	23c If yes outcome	of programov					
B 0)	eath ce ettend for use	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	y		23d. Date ∯ de Month	Day Year
P.O.	at the de by the	Completed by Physician	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknown	tano or death	3 Guiler (specify)				
	that ned by deta	F	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
rds	quires n sign uld be	함	METASTATIC	UTERIN	E CAN	ICER		1 ☐ Ye	s 2□No 3□P	robably 4 dunknown
8	law requires been si	Siete						24a. Was an	24b. Were a	utopsy findings available
æ	The It	E						autopsy perform	ed2 death?	completion of cause of s 2□ No
ital	sicien: The certificete he rector, page	Bec	25. Was case referred to medical				26. Place of Deal	h (Check only one		
>	Physic this ce al direc	10E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	nt 2□ ER/Out	patient 3 DOA	her: 4 🗆 Nursing Ho	ome 5 🗆 Resider	nce 6 □Other (Spe	ecify)
0	ng Ph Vier th uneral	Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui	ry 28b. T Year) In	jury Wo		28d. Describe hor	w injury occurred	
Sio	death. death. ctor: A	cati	2 Accident investigation 3 Suicide 6 Could not be]Yes 2□No	201 1		
Division of Vital Records,	al or Attending F sefter death. f Director: After d in by the funera	Certification;	4 ☐ Homicide determined		iry - At nome, tar c. (Specify)	m, street, factory, office		City or Town,	eet and Number or F , State)	urai Houte Number,
_	spital ours neraf filled		29a. Certifier 1 Certifying Pl	veicion: To the best	of my knowledge	death occurred at the t	tne data and place	and due to the ca	unals) and manner a	s stated
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate hes been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medicai	(Check only 2 Medical Example)	miner: On the basis of and manner sta	examination and	Vor investigation, in my	opinion, death occur	red at the time, da	ite and place, and du	e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. Licen		29	d. Date signed (Mon	*
	1		July MO			D00	63498		9/28/06	
-	14		30. Name and address of person who							
	1 1			WADHWA						
	Sta Registi		31. Date filed (Month, Day, Year) OCT 0 5 2	32. Hegistra	ar's Signature	Sparke				
			00100	Far Ball	- W					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month September 28, 2006 3:30 P M Vincent Moore /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homewood of Williamsport Williamsport Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 219-01-7486 86 Director Feb. 13,1920 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f ehow r than "natural", or Items 23a or 28a-f ehov The Madical Example: Must be notified at 1X Yes 2 □ No Director Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Ave. #116 21795 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. t 1 Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lead Lineman Electric Company permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any ujury or other traumatic event, 900.8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Grant L. Hoffman Hazel E. Hull 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth A. Moore/Wife 16505 Virginia Ave., #116, Williamsport, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 9/30/2006 Smithsburg, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 5. Mark Su 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cerebrovascular accident 3 days /Medical Due to (or as a consequence of): Examiner Fibrillation atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed atherosclerotic cardiovascular disease Due to (or as a consequence of) ettending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical the s IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ል signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown multiple baral cell cancers of skin 1 ☐ Yes Completed peripheral vascular 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' failure certificate renal 1 Yes 2 No : After this certifical funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: And in by the f 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) mpletely filled in by 4 Homicida within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Cyntha Kuttner-Sando mp D47451 September 29 2006

Registrar DHMH 17 Rev 1/2001

State

Cynthia

31. Date filed (Month Day (Year) 2006

Kuttner-Sands no 14214 Paradise Church Road,

Hagerstown,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of	Maryland /		artment o			nd Mei		giene Reg. No.	006	31803	
	Physici	an	Decedent's Name (First, Middle, La		_					2.	Date of De Month	Day	Year		
	/Medic	al	Lillian	Marti			4b. City, To	ven orlo	antion of		Sept	28	06 County of Dea	4:45 P M	_
	Examin	er	4a. Facility Name (If not institution, giv Sacred Heart Hosp		er)			berla		Death			legany		
	Funeral		5. Social Security Number 6. S	Sex 7.	Age (In yrs. last I	birthday)	If Under 1	Year If	Under 24	4 Hrs. g.	Date of Bir (Month, Da	th	9. Bi	rthplace (State or Foreign	_
	Director		219-46-0398	I □ M 2 1 F	87	Yrs.	NOTITIS	Jays	logis	M	lay 4	1919		aryland	_
	land bw		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Limits	_
	Many I sh	tor	Md Allegany	7	Weste	rnpo	rt							1 ☐ Yes 2 🛣 No	
	th the	lirec	10e. Street and Number			=	10f. Zip C	ode				10g. Citiz	en of What C	ountry?	
	death with the Maryland ima 23a or 28a-f show f.rrust.be.notified at	rai	23502 Coon Hollow			1	2156						ed Stat		
	ter de Itema	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 Yes 2	es?	13.	Was Deceder f Yes, specify	nt of Hispa / Cuban, N	anic Origi Mexican,	Puerto Ric	y Yes or No an, etc.))- 1	Black, Wh	erican Indian, ite, etc.	
920	urs af	by F	3 ₩idowed 4 Divorced	If Yes, Give Year or Date	Λ		1 ☐ Yes 2. X	No S	Specity:			3	Specify: Wh	nite	
21215-0036	72 hours after natural', or Ite	Completed by Funeral Director	15. Decedent's E (Specify only highest gr.		16	(Give	dent's Usual (done durii	n ng most o	of working		16b. Kin	d of Business	s/Industry	
121	within ene. than *	mpl	Elementary/Secondary (0-12) Unknown	College (1-4	or 5+)		DO NOT use	,				7.	Iomo		
9	filed v Hygie other i		17. Father's Name (First, Middle, Last)		HOU	sewife		l. Mother	's Name (F	irst, Middle		Iome Sumame)		-
<u>la</u> n	fental fental rked o	To Be	George Crawford]]	Mary	Ann	Klips	tien			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at		19a. Informant's Name/Relationship	Type, Print)								-	Town, State,		
2 €	l and lealth m 27 her tr		Donald Martin/ so	on			Stone		n Rd	l, Wes			1d 2156	r Town, State	-
Jor	Pages 1 nent of P ant: If ite ury or ot		20a. Method of Disposition 1. Burial 2 Cremation 3	Removal from St	ate ceme	tery, crer	natory or othe	er place)	1	0/1/0					
Baltimore,	그런판를		21. Signature Fune Service Lice		Mart	22	emeter Name and	Address o	of Facility	is is			ernpor		-
Ba	Depa Impo any in		1X/			Во	al Fun	eral	Hom	e,111	Chur	ch, We	stern	port, Md 2156	2
	Physician /Medical Examiner	9.	23a. Part 1. Ever the disease, or conshock or leart fatture. List only Immediate Cause (Final disease or condition resulting in death) Seguentially list conditions, if any leading to immediate	a. Due to (or	as a consequence	200 Spee of):	ma)	of dying, s	Such as c	eardiac or ri	espiratory a	rrest,	h_	Approximate Interval Between Onset and Beath	•
92.09	death certificate be executed e attending physician and of for use as the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	as a consequenc	ce of):									
.O. Box 6	the the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetal dea nt at time of death		Ectopic preg Other (spec					2	3d. Date of do Month	elivery Day Year	
<u>α</u>	ires tha signed d be de	þ	Part II. Other significant conditions	contributing to dea	th but not resulting	g in the u	nderlying cau	ıse given i	in Part I.			obacco us Yes 2		to the cause of death? Probably 4 Unknown	
Vital Records,	The law ate has b page 2 si	Completed									24a. Was auto perfo 1 ☐ Yes		death?	autopsy findings available completion of cause of as 2 No	
Vita	Physician: 1 this certificat ral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Othor			Check only				
o	te f	ation; To	1 Yes 2 No 27. Mannier of ∠eat 1 ANatural 5 Pending 2 Accident investigation	28a. Pate f Month,	oatient 2 □ ER/ Injury 28t Day Year)	Outpatier b. Time o Injury		c. Injury at Work?		286	d. Describe		Other (Sp	ecity)	
Division	Dir Dir	Certification;	3 ☐ Suicide 6 ☐ Could not to determined	288. Place 0	f Injury - At home, j, etc. <i>(Specify)</i>	, farm, str	eet, factory, o	office		281		Street and wn, State)	Number or F	Rural Route Number,	
	the Hospital hin 24 hours i the Funeral npletely filled	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the b minar: On the bas and manne	is of examination	dge, deat and/or in	h occurred at vestigation, ir	the time, n my opini	date and ion, death	d place, and h occurred	d due to the at the time,	cause(s) a date and	and manner a place, and di	as stated. ue to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	10			29c. I	License n	umber	ri:1	2	-	77 2	nth, Day, Year)	,
•			1 0//	XI	4 4)_	Deletion 1	100	015	740	7	TEP	ember	129, 200K)
		6	30. Name and address of person who Dr Shin Kim, 90 I					- 0				/			
	Sta Registi		31. Date filed (Month, Day, Year)	32. Rec	JESLEMPO gistrar's Signature	A	id 2156	2							

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 31804 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 22,2006 **Physician** 2310 Sara Catherine Minker /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Havre de Grace Harford Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 26,1923 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2180 F Maryland 82 Yrs. 195-14-2564 Director Usual Residence of Decedent 10d. Inside City Limits r 28a-f show 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Director Cecil Port Deposit Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ir than "natural", or itams 23a or the Madical Examiner must be 58 North Main Street 21904 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) V.A. Medical Center Elementary/Secondary (0-12)
Twelve Years College (1-4or 5+) Perry Point, Maryland Housekeeping Service 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) 1 end 2 should be Heelth and Mental Harry E. Riale, Sr. Florence Weir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 at Deperment of Heelth ar Importent: If item 27 is eny injury or other trau Dana B. Stewart (daughter) 75 North Main Street, Port Deposit, MD 21904 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State West Chester, Pennsylvania R.A. Ferris & Co., Inc 09/24/06 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service License Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4960 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence di Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physiclen and the for use as the buriel-transit Measures Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate 2 No 1 Yes 2 🖪 No 1 Tyes Division of Vital Attending Physician: Director: After this certific d in f y the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 2 ER/Outpatient 3 DDA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Cert fication: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide after To the Hospitel or within 24 hours a completely filled Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madica Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 0662903 23/06 and address of person who completed cause of death (Item 23a) (Type, Print) 319 Sunion Ave IMD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1 1 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 20, 2006 **Physician** Mills 6:45A. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hillhaven Assisted Lvg.,Nursing and Rehab.Ctr. Adelphi Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 8, 1911 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Hours Months Days Min 1 □ M 2√2 F 577-01-0523 94 Washington.DC Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County Show ral, or items 23a or 28a-1 show 1 ☐ Yes 2 No Maryland Prince George's Adelphi Completed by Funeral Director 10e. Street and Number 3210 Powder Mill Road 10g. Citizen of What Country? 10f. Zip Code 20783 United States death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury grother traumatic event, Ite M. dical Even in each once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager C&P Telephone Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Roland Edgar Lee Nora Ann Virginia Nothey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) R. Gregory Mills -son 19820 Spurrier Avenue Poolesville, Maryland 20837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 9/25/2006 Suitland, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bonald V. Borgwardt Funeral Home, PA Donald 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Pneumonia 2 weeks /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease 10 years Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Dementia; Hypertension 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No certificate 1 Tyes the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After Injury 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral (🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature a 29c. License number 2 September 20, 2006 D0031563 ID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles M. Benner, M.D. 10801 Lockwood Drive, #205 Silver Spring, Maryland 20901 31. Date filed (Month, Day, Year) 32 Registrar's Signature SEP 21 2006 Registrai

State of Maryland / Department of Health and Mental Hygien U U 5 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** CAROLYN MCCULLOUGH TUCKER 12:45 P M SEPTEMBER 18, 2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2₩F 85 Yrs. 578-48-4205 12/22/1920 VIRGINIA Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No MARYLAND PRINCE GEORGE'S HYATTSVILLE Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20784 U.S.A. 7003 FARRAGUT STREET filed within 72 hours after death i Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: WHITE Specify: þ 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOME MAKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H lent: If item 271e marked off ELLINOR TAYLOR EUGENE TUCKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4120 WEEPING WILLOW LANE, HUNTINGTOWN, MD 20639 J. GLENN MCCULLOUGH/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Department Importent: It eny Injury o HUNTT CREMATORY 9/20/2006 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME, House 16000 ANNAPOLIS ROAD, BOWIE, MARYLAND 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ventricular Fibri Nation **Physician** nows /Medical Due to (or as a consequence of) Examiner Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed physicien and sthe burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) the t 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ierel Director: After this of filled in by the funeral directors. 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier verd Bah, MD 9/18/06 D46052 30. Name and address cipperson, who completed cause of death (Item P3a) (Type. Print) way, and polis, Mo 10 31. Date filed (Month, Day, Year) 32/ Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

SEP 2 0 200b

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar # 20b, per F. Home, 9/25/06, Certificate of Death B.A., WCHD Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 0655 Ethel Louise Robinson Neely 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sal sbury Hospice At the pastal icomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ XF Days 82 Yrs 579-20-8125 Washington, D.C. Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23a or 28e-f ehow the Medical Examinar must be notified at MD Ocean City 1 X Yes 2 □ No Worcester Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21842 US 113A Newport Bay Dr. death . Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant NCR Corporation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Depertment of Heatih and Menial Hy Important: If item 27 is marked oth any injury or other traumatic event once. Roberta Ethel Gardner William Thomas Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108B Newport Bay Dr., Ocean City, Md. 21842 Susan N. Shoop (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 9-25-2006 20c. Location - City or Town, State 20a. Method of Disposition 1 € Burial 2 Cremation 3 Removal from State Epworth Methodist Cem. 9-29-2006 Rehoboth Beach, DE 4 ☐ Donation 5 ☐ Other (Specify) Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 21. Signature 108 William St., Berlin, Md. 21811 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Netostetic **Physician** (021168 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 conths?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 I Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 12-Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificete has the 212 No 1 🗌 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 In atient 2 ER/Outpatient 3 DOA 1 ☐ Yes 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After thi 27. Manner of eath 28c. Injury at Work? 28a. Tate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Medical

31. Date filed (Month, Day, Year) SEP 2 5 2006

SHER

29a. Certifier

(Check only one)

29b. Signature and little of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI

76278

29c. License number

29d. Date signed (Month, Day, Year)

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			Holy Cross Hosp: 5. Social Security Number 6.		7. Age (In yrs.	last hirthday)		Lver	Spri	_	8. Date of Bi		ontgo			r Comian
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Division of Vital Records,	2 4 7 6	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined.	28e. Place	of Injury - At ho g, etc. (Specif	ome, farm, stri					28f. Location (City or To	Street an wn, State	d Number (or Rura	l Route Numb) <i>01</i> ,
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	To To	Σ	29b. Signature and title of certifier	1) 10-				License					te signed (A	Aonth, l	Day, Year)	
			30. Name and address of person who	completed cause	of death (lice	23a) /Tune		0061	/00			J/ Z4/	/2006			
19			Fabienne Santel	, MD 1	500 For	rest G		d. :	Silve	r S	ring, N	4D 2	20910			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 31809 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 27, 2006 2:30 PM **Physician** O'Rourke Alice /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Examiner Frederick Edenton Retirement Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Jan 3, Birthplace (State or Foreign Country) Funeral 1 □ M 2 351-07-0046 95 Wisconsin Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or itama 23a or 28a-1 show other treumatic event, the Medical Examinar must be notified at Maryland Frederick Frederick 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 5800 Genesis Lane 21703 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ☐Yes 2 No 1 XX ever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Keypunch Operator Computer Technology 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be O'Rourke William Daglin Alice ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert O'Rourke, Nephew 4 Grove Avenue, Edgartown , MA 02539 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Ξ 1 Burial 2 Cremation 3 Removal from State Important: I eny injury o once. Smithsburg Crematory Sep 29, 2006 Smithsburg, Maryland 4 ☐ Donaţion 5 ☐ Other (Specify) 21. Signatura of Funeral Service Cic ^{22. Name and Address of Facility}
Keeney and Basford PA Funeral Home
106 East Church St., Frederick, MD 21701 M00706 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final alzherm. 1 **Physician** nalwarten /Medical resulting in death) Due to (or as a consequer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-₽ Due to (or as a consequence of) physicien Physician/Medical as the ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 ☐ No ihe i 9□ Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 - NO or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Hatural death. 1 ☐ Yes 2 ☐ No Director: A 2 Accident 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide after Fo the Hospital within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

DHMH 17 Rev 1/200

29b. Signature and title of certifie

30. Name, and address of person

0 5 2006

lugd 31. Date filed (Month, Day,

P.O. Box 68760,

win completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number

Freder (10)

29d. Date signed (Month, Day, Year)

September 27, 2006

Please Type or Print in Black Indelible Ink Charles W. Over State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day Y September 22, 2006 1629 hrs Medical Examiner Charles William Over Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2 Bush Chapel Road Aberdeen Harford 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director March 9, 1944 Country) Maryland 213-42-4650 62 1 X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2 X No 28a-f shov Harford Bel Air Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygoria House and the fire and a marked other than "natural", or items 23a or 28a-f she injury or other tranmatic event, the Medical Examiner must be notified at once injury or other tranmatic event, the Medical Examiner must be notified at once 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' ö Meadow Springs Lane USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funera 14. Race - American Indian, 8lack 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married Yes 2X No Widowed If Yes, Give Year 1 Yes 2 X No specify White ð 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Construction Owner/Operator 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Charles William Over Sr Catherine Joan Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abingdon, Maryland 21009
Date | 20c. Location - City or Town, State 604 Hookers Mill Rd., Ronald W. Over Sr./ Son 20b. Place of Disposition (Name of cemetery 20a Method of Disposition crematory or other place) Burial 2 K Cremation 3 Removal from State Donation 5 Other Specify 9-27-06 Towson, Maryland Service Corp 21. Signature of Funeral Service Licenses McComas Funeral Home, P. A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 Approximate Interval art I. Enter the disease, or complicity ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical a. Multiple Injuries and compressional asphyxia Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, ner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician/Medical UNPENDED AMENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months?

Box 68760 Records, P.O. certificate has

attending physician or use as the burial -Fo the Hospital or Attending Physician: Division of Vital Director: d in by the f

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Registrar

Ling Li, MD 31 Date filed (Month

Funeral

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Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 No 1 🗸 Yes No 25. Was case referred to medical 26.Place of Death (Check only one) Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) Sep 22, 2006 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject was struck and pinned by a forklift 1622 hrs Natural 1 ✓ Yes 2 No 5 Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide (Specify) Construction site 2 Bush Chapel Road, Aberdeen, MD Homicide 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year)

O.C.M.E.

September 23, 2006

20

111 Penn Street, Baltimore, MD 21201

mo

strar's Signature

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

2006

	1	For State Registrar	State of Ma		Certificat		eath		R	eg. Ne	006	3181
Physician /Medical		Decedent's Name (First, Middle, L		NHOLZE	7 D				Date of Dea Month EPTEM	Day	Year 26, 2	3. Time of Dea
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Department of Hea Importent: If Item any injury or othe once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spectation 2) 21. Signature of Feneral Service Lice	city) MAR	cemete		other place N S nd Address	CEM.	,	2-06	CHEI	TENH	SVILLE, P r Town, State 206 AM, MARYI
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ROBERT J. PORCH 2:00 P M September 28, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Patricia Smith's Tender Loving Care Harford Edgewood 8. Date of Birth Month Day Year 6/17/1914 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑** M 2□ F 197-07-2930 Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow event, the Medical Examiner must be notified at 1 Yes 2 No Harford Darlington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 2418 Shuresville Road 21034 USA 23a Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2V No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: White 3X Widowed 4 ☐ Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) rthan Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Civil Service Pages 1 and 2 should be filed ment of Health and Mental Hyginant: If Item 27 Ia marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Porch Della Hooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marvin Porch/Son 804 Disston View Drive, Lititz, PA 17543 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages i Department of H Important: If Ite any injury or ot once. 1 XBurial 2 Cremation 3 Removal from State Mt. Nebo Cemetery 10/2/2006 Delta, PA 4 ☐Donation 5 ☐ Other (Specify) 21. Signatur of uneral Service Licer 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. Immediate Cause (Final disease or condition EREBROVASCULAR **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner OVER 1 YEAR HEIMERS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. the attending physician hed for use as the buria by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the at Id be detached for ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 PNo 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 1 Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1551577 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ospital ح. 44 hours after dea.. معا Director: After د. المعالم المعالمة المعالمة المعالمة المعالمة المعالمة المعالمة المعالمة المعالمة المعالمة المعالمة المعالمة الم ٩ 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the hest of my knowledge ideath consisted at the time, date and place and due to the cause(s) and misrical as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the 29b. Signature and title of ce 29c. License number 2 DOO16389 30. Name and address of person who completed carrie of death (Item 23a) (Type, Print) 17/6 HARFORD ROAD FALLSTON MD21047 HERFE CTO State Registrar

State of Maryland / Department of Health and Mental Hygien () Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** SEPTEMBER 19 2006 3:58 P M POLLARD RONALD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGES HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) WASHINGTON, DC Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 XM 2 ☐ F Yrs Director 215-64-5944 Usual Residence of Deceden death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Iteme 23a or 28e-f ahow the Madical Examiner must be notified at 1 X Yes 2 □ No Director RIVERDALE PRINCE GEORGE'S MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20710 5416 JEFFERSON STREET # A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ent of Health and Mental Hygiene. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Ď 3 ☐ Widowed 4 St Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BLACK CONSTRUCTION 11th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FRANCIS POLLARD ANDREW POLLARD SR. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5006 57th AVENUE # C-3 BLADENSBURG, MARYLAND 20710 RONALD POLLARD/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐Donation 5 ☐ Other (Specify) MT. OLIVET CEMETERY 9/25/2006 WASHINGTON, DC 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part . Ent in the se, or complications in a fine of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fine. List mit me cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Jatal CREdic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attanding Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) Physi 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? certificete 1 Yes 2 🛭 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 K ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No I Diractor: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral C 29a. Certifier 🌠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY, MD 20185 GARY HOSPITAL 31. Date filed (Month, Day, Year) 300 32. Registrar's Signature State SEP 2 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician September 19,2006 1227 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Cheverly Prince George County Hospital Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 1931 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex / Funeral 1**∑**M 2□F Virginia 75 577-40-8323 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County or 28e-f show traumatic event, the Medical Examiner must be notified at 1 TYes 2 No Maryland Prince George's Director Oxon Hill 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 United States 812 Neptune Avenue Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1X Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled None Unknown Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Health and Mental H lant: If item 27 is marked of Alonzo Price Anna Belle Brice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 812 Neptune Avenue, Oxon Hill, MD 20745 Florence Caldwell/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State September Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Resurrection Cemetery 23, 2006 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 21. Signature of Funeral Service bicensee 1661 Good Hope Rd SE, Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final vom BED with complications **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit DRADYCARDIA that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) ed by the a detached f 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unknown 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No DHYENIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No After an article of the funeral director, programment of the funeral director director, programment of the funeral director or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၀ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification; Injury 23CM Natural 5 Pending Se prember 8 2006 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide investigation within 24 hours after deat To the Funerel Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 812 1000 Turns 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide tre mu DAWN HERR 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) DMC 29b. Signature and 29d. Date signed (Month, Day, Year) death-(Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Sign State SEP 2 5 2086 Registrar

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 22:35M Maggie Viola Renn 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown 7. Age (In yrs. last birthday)

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18 Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) June 29, 1911 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number **Funeral** 1□M 2₽F 219-74-5147 Director Usual Residence of Decedent 10b. County Washington with the Maryland ^{10a. State} Mary land 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28s-f ehow The Medical Examiner must be notified at Boonsboro 1 XYes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21713 141 South Main Street U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Infinortant: If item 27 is marked other then "naturel", or its marked any injury or other traumatic event, the Medical Evantres once. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XÑo Specify: White þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lee Theodore Frve Ellen Leona Stocks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Alice Heffner/Daughter 5909 Dorsey Drive, Frederick, MD 21703 20b. Place of Disposition (Name of Mountaine Of Central Place)

Date

20c. Location - City or Town, State

2006 Frederick, MD 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral ervice License ^{22. N} Re and Address of Facility Reeney and Basford Funeral Home 106 Fast Church Street, Frederick. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on early line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 30 min /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or us a contactions of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2/2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 ☐ Inpatient 2 ☐ R/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation i Director: A 2 Accident within 24 hours after des To the Funeral Directo completely filled in by th 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 32518 30. Name and addre's of person who completed cause of death (Item 23a) (Type, Print) Dudhe W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 0 5 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrer Reg. No Z U U 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 29, 2006 **Physician** 5:25 AMM Melvin Erie Ringer /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Glade Valley Nursing & Rehabilitation Center Walkersville Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Mours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 x M 2 □ F 220-42-6193 63 Sept. 12, 1943 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. Count 10d. fnside City Limits or 28a-f show ul Hygiene. other then "natural", or itame 23a or 28a-f shov vent, the Madical Examinat must be notified at Maryland Frederick Walkersville 1 XYes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9408 Farmingdale Ave. 21793 U.S.A. death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 MYes 2 □ No If Yes, Give Year or Dates: 1961–1967 filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1☐ Yes 2√ No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12. Colfege (1-4or 5+) Analysts Federal Government of the state of th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be like Department of Heelth and Mental Hy important; if Item 27 is marked oth eny injury or other traumatic event 9DRs. Be Albert Melvin Ringer Margaret Coblentz Biser ٩ 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Theresa M. Ringer, wife 9408 Farmingdale Ave., Walkersville, MD 21793 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Smithsburg Crematory Sept. 30, 2006 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Reeney and Basford PA Funeral Home 21. Signature of Funeral Service Licenses MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Setween Onset and Death Immediate Cause (Final ALZheimers Physician disease or condition resulting in death) DISCASE yens /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine iding physicien end ise as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Deizure oisorder 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2□ No 1 Yes 1 🗌 Yes After this certification tuneral director, I 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1☐Yes 2₺No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. fnjury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending death. 1 Tes 2 No investigation Director: / 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours-efter To the Funeral Dire 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier 29c. License number MD September 29, 2006 D40307 4eul 15. (asaly conce 30. Name and address of person who completed Jouse of death (Item 23a) (Type, Print) Eugene B. Casagrande, M.D., 1564 Opossumtown Pike, Frederick, MD 21702 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Box 68760,

Division of Vital Records, P.O.

2006

in Resident

Physician Michael Bost Ringelsen Examiner Functal Doctor's Community Hospital Lanham Doctor's Community Hospital Lanham Functal Division of Davis Prince George's Lanham Functal Division of Davis Prince George's Lanham Functal Division of Davis Prince George's Lanham Functal Division of Davis Prince George's Lanham Functal Division of Davis Prince George's Lanham Functal Division of Davis Prince George's Lanham In Seas are functio			1 - For State of Maryland / Department of Health and N Certificate of Death		ene g. n2 0 0 5	31817
Social Security Number 0.5 sex 1 m 20 F 7. Age (in yrs. ast chimchay) 10 months	/Mc	edical	Vickie Bost Ringeisen 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	SEPTEMB	Day Year SELL F3 3006 4c. County of Death	
100 Street and Number 10f. Zp Code 10g. Cilizen of What County?	Direct		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Annual Months Days Hours Min.	(Month, Day,	Year) 9. Birthp	place (State or Foreign ntry)
The property of the property o	or death with the ltems 23a or 28a	Funeral	Maryland Prince George's Lanham 10e. Street and Number 9114 7th Street 11. Marital Status 1 □ Never Married 2 □ Married 10f. Zip Code 20706 11. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No 11. No Armed Forces? 1 □ Yes 2 ☒ No		g. Citizen of What Cour U.S.A. 14. Race - Americ Black, White,	can Indian, etc.
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Between chost and Deat disease or condition resulting in death) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Between chost and Deat disease or condition resulting in death) 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Between chost and Deat disease or condition resulting in death) 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Between chost and Deat disease or condition resulting in death) 25a. Due to (or as a consequence of): 25b. Due to (or as a consequence of): 25c. Due to (or as a consequence of): 25c. Due to (or as a consequence of): 25c. Due to (or as a consequence of): 25c. Due to (or as a consequence of): 25d. Date of delivery 2	d 21215-003 d 21215-003 filed within 72 hours Hygiene. Arytiene. Ant the Medical Exp	ted	3 Widowed 4 Noroced Year or Dates:	king	6b. Kind of Business/In	dustry
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Section Sect	/Medic Examin	al Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if airly, leading to initine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			Interval Batween Onset and Death Z
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27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? Month, Day Year) 28d. Describe how injury occurred 28d. Describe how injury occurred	Sion of Vi tending Physical leath. tor: After this cer	cation: Te	examiner? 1	lome 5 Resider 28d. Describe how	nce 6 Other (Speci w injury occurred	
Duliding, etc. (Specify)	DIVI ospital or At hours after c uneral Direct iv filled in by	Sal Certifi	4 Homicide determined 288. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check out)	City or Town,	, State)	stated.
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	To the Hi within 24 To the Fa	M	29b. Signature and title of certifier 29c. License number	29	9d. Date signed (Month,	Day, Year)
Michael Berard, My D26287 9/22/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Berard 7305 Baltimore Blvd 107 College Park 1007 2074 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	CR (10)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Bund 7305 Balthmore Blud 107	College	Park R	20740

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 2 2006

2. Registrar's Signature

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State Registrar

Medica

29a. Certifier

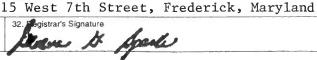
(Check only one)

29b. Signature and title of certifier

Alan Rohrer, MD

31. Date filed (Month, Day, Year) SEP 2 5 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



at home

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D37197

Pike, Adamstown, MD

Physic /Medi		1. Decedent's Name (First, Middle, La	BBNA: A	DERN	Robes	ΔοΔ	2. Date of Dea	Day	Year CO C	3. Time of Dea 9:52a
Exami		4a. Facility Name (If not institution, giv		~	T	or Location of De	ath		ty of Death	M
uneral irector		215-44-8848	1 □ M 2 1X F	(In yrs. last birthday) 61 Yrs.	Months Days	If Under 24 H Hours Mi				ace (State or Fo ry) Land
f show	or	Usual Residence of Decedent 10a. State 10b. County MD Garre	ett	10c. City, Town or Lo					10	d. Inside City Li
r 28a	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
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r neam and wenter hyberter Item 27 is marked other then "neturel", or items 23s or 28s-1 ehow other treumatic event, the Madical Examinar must be colified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 XN If Yes, Give Year or Dates:	lo	Was Decedent of HIYes, specify Cub	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ace - America ack, White, e ify: W	
then "neture Medical	Completed	15. Decedent's Elementary/Secondary (0-12)	ade com <i>pleted)</i> College (1-4or 5-	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w		16b. Kind of E		,
other then		17. Father's Name (First, Middle, Last,	l year	Beaut	ician/Co		ame (First, Middle,	Beau Maiden Suma		р
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is ma reuma		19a. Informant's Name/Relationship (* .		•		Rural Route Numbe	. ,		,
tem 27 i		H. Darwin Robeso 20a. Method of Disposition	n/husband	228 20b. Place of Dispo		New Germ	nany Road,	Frost 20c. Location		
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	/Media		PAUL PATRICK	RICHARDS	S				PTEMBE		006 9:03 a M
	Examir	er	4a. Facility Name (If not institution, given ST. MARY ST. HOSPIT				n, or Location on NARDTO			4c. County of De	
_	Funeral		5. Social Security Number 6. 5		(In yrs. last birthday)	If Under 1 Yea	ar If Under 2	24 Hrs. 8. Da	te of Birth	9. F	Birtholace (State or Foreign
	Director		215-78-3227	10XM 2□F 39	9 Yrs.	Months Day	s Hours	Min. NOV	onth, Day, Ye	966 M	Country) ARYLAND
	D .		Usual Residence of Decedent 10a. State 10b. County	1	I0c. City, Town or Lo	ocation					10d. Inside City Limits
	Aaryla Febor	৳	MARYLAND CHARLES		ioo. Oxy, rown or Ex	NEWBU	IRG				1 Yes 2 No
	the N	Director	10e. Street and Number	,		10f. Zip Code			10g.	Citizen of What	Country?
	h with		13132 SANKSTON DI	RIVE		20	0664			UNITED S	STATES
	deat	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent o	of Hispanic Orig	gin? (Specify Ye	etc.)	14. Race - Ar Black, W	merican Indian,
36	or th	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1	1□Yes 2█N		, , , , , , , , , , , , , , , , , , , ,	,	Specify:	
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altimore, Maryland 21215-0036	s 1 and 2 should if Health and Men item 27 is marke other traumatic		SARAH F. RICHARDS	** *		-				ty or Town, State	P.O.B 248
ē,	s 1 and 3 f Health item 27 other tra		20a. Method of Disposition		20b. Place of Dispo			EPTEMBE		Location - City	
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alti	permit. Pege Department Important: Il any injury o		21. Signature of Funeral Service Lice	PEGO / M000	053 2	2. Name and Add	dress of Facility				MD 20604
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	pital	2	29a, Certifier 1 Certifying Pt	nysician: To the best of a	my knowledge, deat	h occurred at the	time date and	t place, and due	a to the cause	a/s) and manner	as stated
	To the Hospital or Att within 24 hours eftar de To the Funeral Direct completely filled in by t	edicai	(Check only 2 Medical Examone)	miner: On the basis of example and manner state	xamination and/or in	vestigation, in my	y opinion, deat	h occurred at th	e time, date	and place, and d	lue to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	mo	1	29c. Lice	ense number		29d.	Date signed (Mo	onth, Day, Year)
			NN	-	M.D.	D	6088	38		09/2	2/06.
	NE!		30. Name and address of person who	completed cause of dear	th (Item 23a) (Type,	Print)					
	Sta	ta	DR RAKHT KRISHNAN 31. Date filed (Month, Day, Year)	SHAH ASSO	C LEONARD	TOWN MD	2065	0			
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U	J	1	U	6	-

			1- State of Maryla Registrar	_	artment of F tificate of I		ntal Hygier _{Reg. I}		0.020						
	Physic /Medi		Decedent's Name (First, Middle, Last) JOHN JOSEPH STRMEL		SE	2. Date of Death Month PTEMBER	Day 28 200	3. Time of Death 6 9:20a M							
	Exami		4a. Facility Name (If not institution, give street and number) 10 3rd Ave.		4b. City, Town, or Earley	r Location of Death		4c. County of Death							
	Funeral Director		162-28-3507 ¹ ¹ 2 M ² □ F 71	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min. J	Date of Birth (Month, Day, Yea une 17	Q Right	place (State or Foreign intry) nnsylvani						
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	h with the 23a or 28 st by not	Funeral Director	10e. Street and Number 10 3rd Ave.		10f. Zip Code 21919)	_	Citizen of What Cou	intry?						
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28e-f show enty injury or other traumatic svent, it Medical Examera must be notified at once.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Dovorced 12. Was Decedent Ever in Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 12 No	ispanic Origin? (Speci in, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White Specify:							
21215-0036	d within 72 hogiene. giene. er then "natu	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 2.		lent's Usual Occupi kind of work done of DO NOT use retired	ation during most of working () cator	1 4	Kind of Business/Ir per nufactu	,						
Maryland	uld be file fental Hyg rked othe tic svent,	To Be C	17. Father's Name (First, Middle, Last) Jack Strmel			18. Mother's Name (Anna Mc	First, Middle, Maid	en Sumame)							
arý	2 shot and N Is ma		19a. Informant's Name/Relationship (Type, Print)			and Number or Rural F	-								
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68760,	rificate be executed og physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consecutive co												
.O. Box	The law requires that the death certificate tite has base signed by the attending phy age 2 should be detached for use as the	Physiclan/Medlcal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	tal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year						
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Division	<u>•</u> # # = =	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be building, etc. (Special Could not be building, etc. (Special Could not be building, etc.)	eet, factory, office 28f. Location			on (Street and Number or Rural Route Number, Town, State)								
	ths Hospitel or hin 24 hours afte the Funerel Dir npletely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kn and manner stated.	owledge, death ation and/or inve	occurred at the time estigation, in my op	e, date and place, and pinion, death occurred	due to the cause(at the time, date a	s) and manner as s nd place, and due t	stated. to the cause(s)						
1	To the P within 24 To the F complete	M	29b. Signature and title of certifier		29c. License D356		29d. D	ate signed (Month,	Day, Year)						
	~4		30. Name and address of person who completed cause of death lite	m 23a) (Type, F	Print)			121/00							
	Q		Martha Hosford-Skapof,	am Arren		High St.	E1kton	MD. 2	1921						
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06-07314 Gloria Lee Stone

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Provided Name Provided Nam	Jona Lee Glon		1- For State Registrar	ite or Maryland /	•	cate of E		ia wen	,,,	Reg. No. 20	06 3182
45 Secular Security Programs North Sandgates Road Route 25 Security Florage The Control of			1. Decedent's Name (First, Middle,		one						
Second Science Function of Control Discourse Con		,	4a. Facility Name (if not institution,	, give street and number)					f Death	4c. County of De	
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30. Name and address of person who complete cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month Pat Year) 5 2000 32. Registrar's Signature		Σ	29b. Signature and title of certifier	N- 1			1			1	
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	ω		Theodore M. King, Jr., I	MD. Assistant Me	dical Exar	miner 11	1 Penn St	treet, Balt	timore, MD 2120	1	
registrati	Si Regis		31. Date filed (Month Dat, Year) 5	ZUU0 32. Registrar's	s Signature	September 1	St. A.				

Box 68760,
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	-	State of Maryland / Departs State of Maryland / Departs State Registrer Certif		ental Hygie	•
Physicia /Medica Examine	al -	Decedent's Name (First, Middle, Last) Verna Lee Shadwell	b. City, Town, or Location of Death	2. Date of Death	Day Year 3. Time of Death 4c. County of Death
Funeral Director		Lions Rehabilitation Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Cumberland Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y Apr 9, 19	Allegany 9. Birthplace (State or Foreign Country) MD
ne Maryland 8a-f show	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati MD Allegany Cumbel	rland		10d. Inside City Limits 1,☐ Yes 2 ☐ No
ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23e or 28e-f show or other treumetic event, the world Examinating must be collined at	Funeral Director	220 Somerville Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Il Ye	10f. Zip Code 21502 5 Decedent of Hispanic Origin? (Spears, specify Cuban, Mexican, Puerto I		I. Citizen of Whal Country? USA 14. Race - American Indian, Black, White, etc.
hin 72 hours at 3. an "naturel", or W. dical Ex.m.	Completed by	3 ▼ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent (Give kinc.)	Yes 2 No Specify: 's Usual Occupation of of work done during most of workil NOT use retired)	ng	Specify: White ib. Kind of Business/Industry
2 should be filed within and Mental Hyglene. Is marked other than eumetic event, the Mental Hyglene.	To Be Con	12 clerk 17. Father's Name (First, Middle, Last) unknown	18. Mother's Name Minnie B	(First, Middle, Ma	ackies Bakery son) Swick
		Marsha Kammauf daughter 811 Bit 20a. Method of Disposition 20b. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob. Place Ob	Address (Street and Number or Rura rookfield Avenue on (Name of ony or other place)	Cumber	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tre		4 Donation 5 Other (Specify)		me, PA	Cumberland MD
Physician /Medical		23a. Part Enter the disease, or complications that caused the death. Do not enter the anock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a			
se be vsicia e bur	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med		topic pregnancy her (specify)		23d. Date of delivery Month Day Year
w requires that it been signed by should be detac	٥	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 robably 4 Unknown 24b. Were autopsy findings available
hysicien: The law his certificate has b I director, page 2 si	Be Completed	25. Was case referred to medical examiner? Hospital:	26. Place of Death	autopsy performe 1 Yes 2	d? prior to completion of cause of death? No 1 ☐ Yes 2 No
Attending Phys ar death. ector: After this by the funeral dii	Certification: To	27. Manner of Death 1 Inpalient 2 Et/Outpatient 2 Accident 5 Pending investigation 3 Suicide 6 Couloi not be determined by the suicide suicide 1 Injury 2 See, Place of Injury - At home, Iarm, street.	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	ee 6 □Other (Specify) injury occurred et and Number or Rural Route Number,
To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical Certi	29a. Certifier (Check only one) 29a. Medical Examiner: On the basis of examination and/or invest panels at the company one)	curred at the time, date and place, a		se(s) and manner as stated.
To the within To the compl	Me	29b. Signature and little of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Prince 23a)	29c. License number D33280	Se	Date signed (Month, Day, Year)
Stat Registra	- 14	Dr. Sunil Gupta 625 Kent A 31. Date liled (Month, Day, Year) OCT 0 5 2006 32 Registrar's Signature	Maria Charles	and MD	21502

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2006 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day
September 26 Physician 6:25 РМ 2006 Kraig Adam Stotsky /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month. Day. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 06/18/1966 40 Director 220-84-0569 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f ahow other traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2% No Directo Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 21037 28 Ridge Avenue United States or Itams 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. I fingularist if I tam 27 is marked other than "natural", or tlar any injury or other traumatic avent, the Medical Examples. 2006. 1 Tes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐KNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Mason Tender Masonry 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Adam John Stotsky Dianna D. Watkins 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianna D. Stotsky/Mother 28 Ridge Avenue, Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c, Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Kalas Crematory 10/01/2006 Edgewater, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Euneral Sen 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final Even Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) mon 175 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No page 2 should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Xes 2 🗆 No 3 Probably 4 Unknown been (24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 1 Yes 2 No 1 ☐ Yes 2/2 No Division of Vital in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident s after death 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours after within 24 hours a To the Funeral L Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of portifig person who completed cause of death (Item 23a) (Type, Print) MO 900 32. Aegistrar's Signature State Registrar

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RE	3)		30. Name and address of person who cou	npleted cause of death (Item HMEM M	n 23a) (Type,	Print)	UNIVE	ERSIT	V BLVD	Silv	ER SAR	20903 ING, Md.
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo	th, Day, Year)
1 1000 fee 37 8009	,6
30. Name and address of person who completed cause of death (Item 23a) (Type, Print). MANZIAR. DSHAPI 368 Well Street Heighsterm PCD	9 17/. 0
	11170
State 31. Date filed (Month, Day, Year) SEP 2 5 2006 Registrar 32. Registrar's Signature	

			For State Registrar	State of Mar		artment of		nd Mental F	lygiene	006	31829
			1. Decedent's Name (First, Middle, Last)				2. Date of	Death		3. Time of Death
	Physici /Medic		Louis Schram					Sept.	20^{Day}	2006 ^{Year}	9:22AM M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	n, or Location of	Death	4c. C	ounty of Death)
			Holy Cross Hospita	1		Silve	r Spring	g	Me	ontgome	ery
	Funeral Director		085-10-3092	7. Age	(In yrs. last birthday) Yrs.	If Under 1 Ye Months Day		4 Hrs. 8. Date of (Month, 9-11-	Birth Day, Year) 1914	9. Birth Con Gern	place (State or Foreign intry) 1any
	pug *		Usual Residence of Decedent 10a. State 10b. County	1.	10c. City, Town or Lo	cation					10d. Inside City Limits
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	the A	Funeral Director	10e. Street and Number			10f. Zip Cod		***	100 Citize	on of What Co	into/2
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	eath ne 23	era	3114 Gracefield Ro	12. Was Decedent Ev				in? (Specify Yes or	U.S.A	. Race - Amer	ican Indian
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Maryland 21215-0036	uld be fill fental Hy rked oth tic even	To Be	17. Father's Name (First, Middle, Last) Unknown Schram					's Name <i>(First, Mide</i> nown Un	_{dle, Maiden S} known	umame)	
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Baltimore,	ages 1 and of Hee		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		20b. Place of Disponsion Commetery, creating Garden of	natory or other i	^{ріасө)} 9-	Date -22-06		stion - City or 1	
Ħ	ortene ortene Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens				,	Edward S	ace1	Funeral	Direction
Ва	Deperting any							Pike Roc			
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. aCoronar	y Artery			ardiac or respirator	arrest,		Approximate Interval Between Onset and Death Year
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	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1∑ Certifying Phy (Greck only one)	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	n occurred at the vestigation, in m	e time, date and ny opinion, death	place, and due to to n occurred at the time	ne cause(s) a le, date and p	nd manner as lace, and due	stated. to the cause(s)
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	U		30. Name and address of person who collaborate Loveen J. Puthuman	ompleted cause of dea	ath (Item 23a) (Type.	Print)		.ng, MD 20	904		
ja	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 2 2	32. Begistrar	's Signature	redi					

			for State Registrar	State of	Marylan	d / Depa	artmeni rtificate	t of H e of L	ealth and Death	l Mental Hyg	giene ()	06	31830
			1. Decedent's Name (First, Middle,	Last)		-				2. Date of Dea Month	th Day	Y <i>e</i> ar	3. Time of Death
	Physici /Medio			Char1e	es Euge	ene Se	abo1d			Septemb		2006	8:40a M
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			Montgomery Gen	eral Hospi	ital			01	ney			Montg	omery
	Funeral		5. Social Security Number 6	5. Sex 7. 1 X M 2 ☐ F	Age (In yrs.		If Under Months	1 Year Days	If Under 24 H Hours Mi		Year)	9. Births	place (State or Foreign
	Director		286-24-6525	IZAM ZUF	76	Yrs.				Oct. 6			hío
	put *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ocation					1.	10d. Inside City Limits
	sho	'n	,			,, 10 mi oi E	Joanon						1 ☐ Yes 2 ☒ No
	Ne N	ect		gomery	Dar	nascus	101 7	0.1.			0	/	
	with t	Ö	10e. Street and Number				10f. Zip				10g. Citizen o		
	hours after death with the Maryland tural', or Items 23a or 28e-f show at Examinat rough be notified at	Funeral Director	9208 Woodvale Dr	12. Was Deced	ant Eventin III	C 12	Was David		0872	/S	Unite		
	ltem men	nu	11. Marital Status	Armed Forc	es?	.5.	If Yes, spec	of Cuba	n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. BI	ace - Ameri lack, Whit <i>e</i> ,	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Voc Give	⊔™ ®s:Korea		1 ☐ Yes 2	2 <mark>√</mark> No	Specify:		Spec		• .
21215-0036	hou ture	ed t	15. Decedent's		- KOLES	1	dent's Usua	I Occupa	ntion		16b. Kind of		nite
15	in 72	Completed	(Specify only highest	grade completed)		(Give	kind of wor	k done d	uring most of w	vorking	TOO. PRING OF	D031110333111	idustry
12	within lene. then	шo	Elementary/Secondary (0-12)	College (1-4	lor 5+)	Advis	ory Sy	vste	ns Anal	vst	Т	ВМ	
	Hyg Hyg ther	Ö	17. Father's Name (First, Middle, La	·		I TIC V I D	ory b	, 500		lame (First, Middle,			
an	d be ental	o Be	Russell A. Seabo	1.4					Edra V.	N., 11			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental hygiene. Item 27 is marked other than "netural", or Items 23s or 28e-1 show other treumatic event, its Medical Examinar must be notified at	ပ္	19a, Informant's Name/Relationship			19b. Maili	na Address			Rural Route Number	r. City or Tow	n. State. Zic	Code)
Z	d2 s th ar treu						•			Damascus,	110 F201		
ō,	of Health of Health litem 27 i		Sally Sue Seabol 20a. Method of Disposition	d/ wire	20b. P	Place of Disponentery, create				Datia	20c. Location		
Baltimore,	permit. Pages Department of I Important: if Ite eny Injury or of		1 ☐ Burial 2 ☑ Cremation 3		ate				1	10=104			
Itin	it. P irtme irtan njury		4 ☐ Donation 5 ☐ Other (Special Service ↓		Sta				Inc.9	/25/06	Freder	ick, N	Maryland
Ba	Department Department of the police of the p		21. Signature of directal Services	Ilhou	, /	S	tauffe	er F	uneral	Home P. A			
	_		23a. Part1. Enter the disease, or or	omplications that cau	send the deat							Mary.	Land 21/02 Approximate
	Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one calise on each	h line.	lipe							Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or	as a conseq	uence of):	graci		cong	rideut		-	
	Examiner		Cognostially list conditions	, CORE	BAD	- Va	3846	at	eloc.	i'dent	_		
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a conseq	uence of):							
	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c									
oʻ	en a Irial-	Ä	resulting in death) Last	Due to (or	as a conseq	uence of):							
8760,	ysici nysici	dicai		d									
9	certifica nding ph use as ti	Jed	IF FEMALE										
Вох		Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna h 2 ∏ Feta		Ectopic pr	ennancy				ate of deliv	
	0 0	Sicie	in the past 12 months? 1 ☐ Yes 2 ☑ No		nt at time of d		Other (sp				N	Month	Day Year
P.0	by the	hys	9 🗌 Unknown	9LI UNKNOW	m								
	The law requires that the death sie has been signed by the atte bage 2 should be detached for	γP	Part II. Other significant condition	s contributing to dea	th but not res	ulting in the u	nderlying ca	ause give	n in Part I.	23e. Did to	bacco use co	ntribute to t	the cause of death?
Records,	w require been sig should b	ed								_ 1□Y	es 2 🗆 No	3 🗌 Prot	bably 4 Unknown
00	s been s been s should	oiet								24a. Was a	an 24b	. Were auto	opsy findings available ompletion of cause of
æ	he lav e has age 2 :	E								- autop: perfor	med?	death?	
ta	iffical or. p	Ö	25. Was case referred to medical	-					26 Place of F	1 Tyes	2/D/No	1 🗆 Yes	2L No
of Vital	s cert	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 100	patient 2	ER/Outpatier	nt 3[] DO	Othe	NT.	Home 5 ☐ Resid		th or /Casau	6.)
o	Physical controls	Ξ.	27. Manner of Death	28a. Date of (Month,		28b. Time o		8c. Injury Work		28d. Describe h			(Y)
Division	th.	Certification;	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	Injury	м		:? ∕es 2.∐No				
İSI	dee ctor	fica	3 Suicide 6 Could no	t be 300 Blace of	f Injury - At ho	ome, farm, sti	reet, factory	. office	-	28f. Location (S	treet and Nun	n <i>ber</i> or Rura	al Route Number,
ă	after Olra	erti	4 Homicide	building	, etc. (Specif	y)				City or Tow	n, State)		
	spita ours neraf filled		29s Certifier 1 Certifying	Physicians To the b	ant of makes	awhering don't	h venument	at the tim	s data and ole	sec. and diss to the e	avisofe) and c	machoor as s	data of
	To the Hospital or Attending Physician: The I within 24 hours after deeth. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	edicai		caminer: On the bas and manne	is of examina	tion and/or in	vestigation,	in my of	pinion, death oc	courred at the time, o	late and place	e, and due to	o the cause(s)
	o thin o thin o thin	Me	29b. Signature and title of certifier	4			29c	License	number	2	29d. Date sign	ned (Month,	Day, Year)
	L S L O		1/1001/	Much		MA	1	-171	2594	14	09/1	13/0	6
7	Wash		30 Name and address of paress	no completed cause	of death (Ita-	n 23a) /Tuna	Print'	00	0 / (0//2	-10	
	1,7		30. Name and address of person w	LA//III	1210	L ZSaj Lype,	1100	De	Wih I	A Plan	ech	209	32 MO
	1		31. Date filed (Month, Day, Xear)	32 Rec	pistrar's Signa	ıture -	nce	# #1	11	1. 1.200	1	~ 0	110
	Sta	16	SEP 25	2006	Page a 4	K A	and a		-				

			1 - For Stata Registrar	State of Maryla	_	artment of Heat tificate of De	eath	Reg.	ne N <u>2</u> 0 0 6	01001
	Physici /Medi		1. Decedent's Name (First, Middle, La Oneida Stultz	st)			Se	2. Date of Death Month eptember	19, 200	3. Time of Death 11:25 M
	Examir	ner	4a. Facility Name (If not institution, giv Homewood at Crum			4b. City, Town, or Lo			4c. County of De Freder	
Ŀ	Funeral Director		212-24-0002	7. Age (In yrs	s. last birthday) Yrs.		Hours Min. Jan	8. Date of Birth (Month, Day, Ye nuary 2,	1930 9. E	sirthplace (State or Foreign Country) Maryland
	show	וה ו	Usual Residence of Decedent 10a. State 10b. County Maryland Frederic		City, Town or Lo					10d. Inside City Limits
	ith the M or 28a-f	Directo	10e. Street and Number	K ,	riederic	10f. Zip Code			Citizen of What	★▼Yes 2 No Country?
	death w	Funeral I	7407 Willow Road 11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	21702 Vas Decedent of Hisparyes, specify Cuban, I	anic Origin? (Spec			nerican Indian,
036	ours after ral', or its Evantre	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2€ No If Yes, Give Year or Dates:			мөхісап, Риепо н Specify:	ican, etc.)	Specify:	white
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or itams 23a or 28a-f show event, the Medical Evertine front by Intilified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)	16a. Deced (Give life. L	ent's Usual Occupation kind of work done during OO NOT use retired)	n ing most of working	g 16b	Kind of Busines	ss/Industry
d 21	oe filed within al Hygiene. I other than ivent, Inc. M	Be Con	12 17. Father's Name (First, Middle, Last,		Secre		I. Mother's Name	(First, Middle, Maio	Education Sumame)	on
rylan	should be f nd Mantal h marked of imatic ever	To B	Gerald L. Tucke	-			Mary Fi	rances Fo	g1e	
	as 1 and 2 should to the Mant and Mant titem 27 is marked rother traumatice		19a. Informant's Name/Relationship (Melanie Frank - d.			g Address <i>(Street and</i> Ianda Dr iv e				. <i>Zip C</i> ode) 21769
Baltimore,	Pagas 1 lent of Ha nt: If iter ry or oth		20a. Method of Disposition ★□ Burial 2 □ Cremation 3 □ 4 □ Dogation 5 □ Other (Specified)	Removal from State		sition (Name of latory or other place) Cemetery	9-25-2		Location - City of the Color of	or Town, Slate Maryland
Bait	parmit. Pagas Department of H Important: If ite any injury or of once.		21. Sign three of Funeral Servin Licer		22.	Name and Address of 21 Opossum	of Facility Stau	ıffer Fun	eral Hor	ne
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea					ck, mary	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in dealh)	a. PARKIN Due lo (or as a conse		1 DIZE	ASE			10 425
į.		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conse	quence of);					
Ď,	ceruircata be executed ording physician and use as the burial-transit	Examiner	Cause (Disease or injury that iniliated events resulting in death) Last	cDue to (or as a conse	quence of);					
08/20	g physici as the bu	edical	(d						
C. BOX	ine fav. requires that the death certificate has been signed by the attending to page 2 should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, oulcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗌	Eclopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
, y	signed by	by P	Part II. Other significant conditions of	ontributing to death but not re	sulting in the un	_	_		_	to the cause of death?
ecords,	s been 2 should	ompieted	DEMENT A.	GELD	"} !-	TYPERIE	4210N	1 ☐ Yes 24a. Was an	24b. Were	Probably 4 Unknown autopsy findings available
		e Com	25. Was case referred to medical					autopsy performed 1 Yes 2	death?	
סו אוומ	D (1)	ToB	examiner? 1 ☐ Yes 2 ☑ No		ER/Outpatient	-	i. Place of Death (o 5 ☐ Residence	6 □Other (Sp	ecify)
	aath. or: After thi he funeral	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes	28 2 □ No	ld. Describe how in	jury occurred	
מאום	s after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al h building, etc. (Speci	ome, farm, stre	et, factory, office	28	f. Location (Street City or Town, Sta	and Number or I ite)	Rural Route Number,
200	within 10 per and the formula of the	Medical	29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medical Example	vsician: To the best of my kni iner: On the basis of examina and manner stated.	owledge, death ation and/or inve	occurred at the time, o estigation, in my opinio	date and place, an on, death occurred	d due to the cause at the time, date a	(s) and manner and place, and du	as stated. ue to the cause(s)
-	withi To 11 comp	Ž	29b. Signalure and title of certifier	_ no		29c. License nu	9 3 6		ate signed (Mor	,
-	>		30. Name and address of person who can be a Dowle Liston		п 23a) (Туре, Р	-i				MD 21702
	Stat Registra	16	31. Date filed (Month, Day, Year)	32. Regiorar's Signa	ature	had s		.,,-		

DHMH 17 Rev 1/2001

Oneida Stultz

7.0.0 11.25

1 - State Certificate of L	Health and Mental Hygiene 006 3 832
1. Decedent's Name (First, Middle, Last)	Date of Death Month Day Year
Physician /Medical Mabel Elizabeth Savage	Sept 20 2006 2:40 P M
	r Location of Death 4c. County of Death
Dennett Road Manor Nursing Home Oakland	
Funeral 1 M 2 XF Months Days	If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country)
Director 216-90-2810 90	April 19 1916 Maryland
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Garrett Oakland	1 ☐ Yes 2 🙀 No
MD Garrett Oakland 10e. Street and Number 10e. Street and Number	10g. Citizen of What Country?
1100 Mary Drive 21550	United States
1100 Mary Drive 21550 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 2 No	Hispanic Origin? (Specify Yes or No-
Armed Forces? If Yes, specify Cuba Armed Forces? If Yes, specify Cuba Armed Forces? If Yes, specify Cuba Yes 2 ☑ No If Yes, Specify Cuba	an, Mexican, Puerto Rican, etc.) Specify: Specify: Specify:
3 \ Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 \ No Year or Dates:	White
The state of the s	during most of working
Elementary/Secondary (0-12) College (1-4or 5+)	
To see the second secon	Own Home 18. Mother's Name (First, Middle, Maiden Surname)
The proof of the p	Mary Elizabeth DeWitt
10a. State 10b. County 10c. City, Town or Location Oakland 10a. State 10b. County 10c. City, Town or Location Oakland 10a. State 10b. County 10c. City, Town or Location Oakland 10b. County 10c. City, Town or Location Oakland 10c. City Town or Location Oakland 10c. City Town or Location Oakland 10c. City Town or Increase or Increase or Increase or Increase or Increase or In	and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Alma Hebden, Sister 710 Pensinger	r Blvd., Oakland, MD 21550
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
E 2 5 1 1	Gardens 9/23/06 Oakland, MD
Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address	The state of the s
K (There are) VILLE ITAL	21 N. Second Street, Oakland, MD 21550
23a. Part1. Enter the disease, or complications that valued the death. Do not enter the mode of dyin shock, or heart failure. List only one cause of each line.	ng, such as cardiac or respiratory arrest, Approximate Interval Between
Physician Immediate Cause (Final disease or condition DEMENT) A	Onset and Death
/Medical resulting in death) Due to (or as a consequence of):	7
Examiner Sequentially list conditions, b.	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	Ů
that initiated events c. Due to (or as a consequence of):	<u> </u>
Due to (of as a consequence of):	
resulting in death) Last Due to (or as a consequence of):	
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.	
The suiting in death Last Due to (or as a consequence of): Due to (or as a consequence of): d. July 15 FEMALE: 23b. Was decedent pregnant. 23c. If yes, outcome of pregnancy.	23d. Date of delivery
Due to (or as a consequence of): Constitution	
Due to (or as a consequence of): Construction	
d. Section Color	Month Day Year Ven in Part I. 23e. Did tobacco use contribute to the cause of death?
d. Section Color	Month Day Year
Spond of the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	Month Day Year Ven in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Spond of the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	Month Day Year Yen in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
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Spond of the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	Month Day Year 23e. Did tobacco use contribute to the cause of death? 23e. Did tobacco use contribute to the cause of death? 24a. Was an autopsy performed? 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 26. Place of Death (Check only one) 27. Nursing Home 5 Residence 6 Other (Specify)
Spond of the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	Month Day Year 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) 196. Place of Death (Check only one) 197. All Nursing Home 5 Residence 6 Other (Specify) 198. All 28d. Describe how injury occurred
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The part of the pa	Month Day Year 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) 10er: 4 Nursing Home 5 Residence 6 Other (Specify) Ty at tri? Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)
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Second S	Month Day Year 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) 1er: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (attention of cause) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Space Spac	Month Day Year 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) 1er: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (attention of cause) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Second S	Month Day Year Year in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 26. Place of Death (Check only one) 1er: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)
Second S	Month Day Year 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) 10 Yes 2 No 27. Place of Death (Check only one) 10 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Describe how injury occurred

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 09/22/2006 1850 M James Charles Skaggs /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Atlantic General Hospital Berlin If Under 24 Hrs. B. Date of Birth (Month, Pay, Year) 07/09/1921 If Under 1 Year 9. Birthplace (State or Foreign Country) I 11 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days XX м 2□ F Yrs Director 337-14-0449 85 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show Examiner must be notified at 1 X Yes 2 No Berlin Director Worcester 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number ō 21811 USA Items 23s 109 Henrys Mill Drive Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1942–62 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 ō 1 ☐ Yes XX No Specify: 3 ☐ Widowed 4 ☐ Divorced "netural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other treumetic event, the Madical Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) US Government Chief Warrant Officer and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Viola Thomas Walter Skaggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 is eny injury or other tre once. 109 Henrys Mill Dr. Berlin, MD 21811 June L. Skaggs (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State 09/25/2006 | Frankford, DE Cape Henlopen Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on enter the mode of dying, such as cardiac or respiratory arrest, 108 William Street Berlin, MD 21811 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** MONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner The law requires that the death certiticate be executed the attending physician and Due to (or as a consequence of) Box 68760 Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 26. Place of Death (Check only one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this te of Injury (onth, Day Year) 27. Mapner of 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No M s atter death. in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide tilled 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manual description.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29c. License number 29b. Signature and title of certifie Name and address of person who completed came of BA 15 State 2006 Registrar

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			For	State of Maryland				Mental Hygi	ene	3.0	01001
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Ļ	/Medic		William	J. IDERI	2	EVENSOR		Septem	er 26, =	2006	1238 "
£	Examin	er	4a. Facility Name (If not institution, give	Street and number)	41	4b. City, Town, or Le	Cation of Death		4c. County of		,
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la.	st birthday)		If Under 2 Hrs.	8. Date of Birth	9	. Birthpl	ace (State or Foreign
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36	or ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🗺No If Yes, Give	+		Specify:		Specify:	171	. 1.
ë	hours ture!	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a Deced	lent's Usual Occupation	00	10	6b. Kind of Busi	-	ack
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<u>Visi</u>	Atter octor by the	Ifica	3 Suicide 6 Could not be 4 Homicide determined		ne, farm, str	et, factory, office		28f. Location (Stre City or Town,		or Rural	Route Number,
Ö	tal or	Certification:	4 Tromede	building, etc. (Specify)				City of Youri,	Siale/		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit		(Check only 2 Medical Exan	ysician: To the best of my know niner: On the basis of examination	ledge, death on and/or inv	occurred at the time, restigation, in my opin	, date and place, nion, death occu	and due to the car red at the time, da	use(s) and mann te and place, an	er as sta d due to	ated. the cause(s)
	thin 2 the the mplet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License r	number	29	d. Date signed (Month. L	Day Year)
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			30. Name and address of p s n who	completed cause of death (Item :	23a) (Type.	Print)	0		09-21	0-0	7000
			TAN, CONSTAN	75 1340 5	-D(U)	1 1	Solis	hy M	D21	80	4
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 3 | 835 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 21,2006 4:50P [™] Sylvia Green Seidler September 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Health Asbury-Solomons Island Care Calvert Solomons If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 X F Months 11,1907 193-32-5420 August Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h Count Calvert Solomons 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11750 Asbury Circle 20688 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify. 3 Widowed 4 □ Divorced 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) School/Education Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Abraham Green Minnie Brown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2450 Fenwick Circle, Bryans Road, MD 20616 Judith Yochelson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Brinsfield-Echols 9/22/06 4 □ Donation 5 □ Other (Specify) Charlotte Hall,MD 21. Signature of Funeral Service Licensee M00945 ÄREHART-ECHÖLS FUNERAL HOME,P.A. St. Mary's Ave. La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death mediate Cause (Final Failure Heart disease or condition resulting in death) ongestive o (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day

Physician /Medical Examiner

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Director: After the in by the funeral

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death certificate be executed

P.O. Box 68760

Division of Vital Records,

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permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 te marked other any injury or other traumatic event, I

Baltimore, Maryland 21215-0036

r than "natural", or iteme 23a or 28e-f ehov the Medical Examiner must be notified at

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 Unknown

5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes

26. Place of Death | Check only one

3 ☐ Probably 4 ☐ Unknown 2 XNo

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ZNo 1 Yes

Location (Street and Number or Rural Route Number, City or Town, State)

25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo 27. Manner of Death

1 Inpatient 28a. Date of Injury (Month, Day Year) investigation

Hospital:

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

30. Name and address of person

tho completed cause of death (Item 23a) (Type, Print)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

5 Pending

6 Could not be

determined

DHMH 17 Rev 1/2001

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06-07336

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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Physician		le qistrar 1. Decedent's Name (First, Middle,Last)							2.	Date of Dea	ath	Year	S Time of Death 3 6
Medical Examin	er	HURBAN E. SANT 4a. Facility Name (if not institution, give street)				o. City, Tow	n. or Lo	cation of D		Septembe	Day er 29, 200	06 eunty of Deat	1130 hrs
		1844 St. Thomas Road	et and number)			Toddville						chester	
Funeral	T	5. Social Security Number 6. Sex	7. Age (Ir	yrs. last birth	day)	If Under 1	$\overline{}$	If Under 2		Date of Bi	rth(MM/DD/	YYYY) 9. Bi Forei	irthplace (State or
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J	—	Usual Residence of Decedent 10a, State 10b, County	1100	c. City, Town o	r Locatio	in.							10d Inside City Limits
ow any		10a. State 10b. County DELAWARE SUSSEX	100	BRIDGE									1 Yes 2 X No
ryland ra-f sh	황	10e. Street and Number				10f. Zip Co	de				10g. Citizen	of What Co	untry?
he Ma or 28	Director	7411 GAMBINOS WAY				1	993	3				USA	
	— L	11. Marital Status 1 Never Married 2 Married	Was Decedent Eve Armed Forces?	er in U.S		Decedent of s, specify C				ify Yes or No can, etc.)	D- 14.	Race - Ame White, etc.	rican Indian, Black,
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urs aft tural'	좕	15. Decedent's Education (Specify only high	ates:	ted) 16a. D	ecedent'	s Usual Oc	cupation	(Give kind	d of wor	k done	16b. Kind	of Business	s/Industry
72 ho	Completed		College (1-4 or 5+)	a		st of workin		ONOTUS	e reurec)	M2	MILERC	MIDING CO
5-0036 iled within 7 Hygiene I other than the Medica	ᇍ	12			-51	5/1/11 1 1	- I-DI	Mothor's A	Jame /E	irst Middle	Maiden Sur		TURING CO.
15-(filed all Hyger ed oth	B B	 Father's Name (First, Middle, Last) GEORGE C - SANTERF 	F				10		,	. YOU!		marrie)	
2121 buld be fi Mental I marked ic event,	일	19a. Informant's Name/Relationship (Type,		19b.	Mailing	Address (Street a					or Town, Stat	te, Zip Code)
MD d 2 sho lth and n 27 is		JOSEPHINE SANTERRE									ILLE,		9933
re, l		20a Method of Disposition 1 X Burial 2 Cremation 3 R	emoval from State		ry or oth	er place)				Date 1/2006		,	or Town, State
Pages nent o ant:		4 Donation 5 Other Specify:		DELAWARE	VETE	RANS C	EMELI	RY 4	09/04	1/2006 	MILL	SBORO,	DELAWARE
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21. Signature of uneral Se pre-tricere	A MOOSE		PAR 202	Selepto 2 Laws	NERA SIRE	ifanome et, br	IDGE	REMATOR	IUM, HA DELAWAF	RDESTY E 1993	CHAPEL 33
Physician		23a Part I. Enter the disease, or complicati		death. Do not	enter th	e mode of d	lying, su	uch as card	diac or re	espiratory ar	rest, shock,	or heart	Approximate Interval Between Onset and
/Medical	- 23	failure. List only one cause on each in Immediate Cause (Final disease a.	rowning										Death
Examiner	-	· · · · · · · · · · · · · · · · · · ·	o (or as a consequ	ence of):									
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cuted	Exai	events resulting in death) Last Due	to (or as a consequ	ence of):									
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Box 6876 e death certificate the attending phy ed for use as the l	Physician/M	1 Yes 2 No 9 Unknown 9		le oi deatii 5	Oth	ner (S <i>pecif</i> y	()						
O. B or the d lby the			tributing to death b			nderlying ca	ause giv	en in Part	1.				to the cause of death?
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Div To the Huspital or within 24 hours aft To the Fineral Di	Medical	one) 2 Medical Examiner: 9n	the basis of examir I manner stated	nation and/or ir	nvestigat	ion. in my o	pinion,	death occu	irred at t	he time, dat	e and place	, and due to	the cause(s)
F % F 8	Me	29b. Signature and title of certifier						number				- ,	Month, Day, Year)
		/ V /L	4				O.C.N	I.E.			Septe	mber 30,	2006
		30. Name and address of person who comp	oleted cause of dea / Chief Medica		111	l Penn S	treet	Baltimo	re Mr	21201			
	ate	Mary G. Ripple MD. Deputy 31. Date filed (Month, Day, Year)	Registrar's				.,						
Regist	ate trar	on balle med (Monthly, bay, real)	Marce o	1 B									
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06-07344 Earle Richard Stevens

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 31837

	1- For State Certific	cate of Death	Reg. No.	
Physician/	1. Decedent's Name (First, Middle,Last)		2. Date of Death 3. Tin	ne of Death
ledical Examine	Zarra Richard Scarens		September 29, 2006 23	345 hrs
	4a. Facility Name (if not institution, give street and number) 1880 Woodbine Road	4b. City, Town, or Location of Death Woodbine	4c. County of Death Howard	
Funêral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last bit 220–46–8330 1 X _M 2 F 53	rthday) If Under 1 Year If Under 24Hrs Months Days Hours Min Yrs.	Foreign	(State or Maryland
	Usual Residence of Decedent			
v any	10a State 10b. County 10c. City, Tow			Inside City Limits
Aaryland 28a-f show 1 at once. ector	Maryland Howard Lisbo	on	1	Yes 2 X No
the Maryland a or 28a-f sh tiffed at once	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
ith the Maryland 23a or 28a-f sho notified at once		21765	U.S.A.	
™ Single	11 Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	 Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto 		dian, Black,
ter death	3 Widowed 4 X Divorced If Yes, Give Year	1 Yes 2 X No specify:	Specify White	
urs aft tural" amine	or Dates:	. Decedent's Usual Dccupation (Give kind of v	vork done 16b. Kind of Business/Industri	
5-0036 cd within 72 hour lygiene. other than "natu he Medical Exar	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life DO NOT use reti Cabinetmaker	Cabinetry	
21215-0036 uld be filed within 72 Mental Hygiene, marked other than 'e event, the Medical To Be Comple*	12		(First, Middle, Maiden Surname)	
21215-003 uld be filed within Mental Hygiene marked other to event, the Med		Carrie		
2121 ald be fill Mental I marked cvent,			Rural Route Number, City or Town, State, Zip C	ode)
MD 3	Carrie R. Seibert - Daughter	11717 Weller Road,	Monrovia, Maryland	21770
ore, M is 1 and 2 of Health If item 2		e of Disposition (Name of cemetery, atory or other place)	Date 20c. Location - City or Town,	State
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental tant: If item 27 is marked or other traumatic event, To Be	T Bullar 2 Cremation 3 Removal non state		5/2006 Mount Airy, M	laryland
Baltimore, permit Pages I at Department of He Important: If ite injury or other tr	21. Signature of Funeral Service Licenses	22 Name and Address of Facility Molesworth-William	s P.A. Funeral Home Damascus, Maryland	20872
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do		r respiratory arrest, shock, or heart App	roximate Interval
/Medical	failure. List only one cause on each line Immediate Cause (Final disease a. Hypertensive athero	sclerotic cardiovascular o		ween Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of):			
	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
ed nsit	cause. Enter Underlying Cause (Disease or injury that initiated			
and and transit				
cian cian	x unpended AMENDED item#23a,PI	I,27,perME,g860,10/25/06	T	
760 icate by physical properties of the pure properties of the pure pure pure pure pure pure pure pur	IF FEMALE: 23c. If yes, outcome of pregnance 23b. Was decedent pregnant in the	у	23d. Date of delivery	Vaca
	past 12 months? past 12 months? 4 Pregnant at time of death	2 Fetal death 3 Ectopic pregna 5 Other (Specify)	ancy Month Day	Year
by the attendir the death cert by the attendir the defendenched for use a physicia	1 Yes 2 No 9 Unknown 9 Unknown			
P.O.		ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cal 1 Yes 2 No 3 Probably	F-3
S, P.C	Chronic alcoholism		24a Was an 24b. Were autopsy	
ords aw requires been as been 2 should				tion of cause of
tal Records, I tian: The law requires certificate has been sig ector, page 2 should be			1 ✓ Yes 2 No 1 ✓ Yes	2 No
tal I	25. Was case referred to medical examiner?	26 Place of Death (Check Outpatient 3 DOA Other Nursin		
fVi Physi er this ral dir	1 V Yes 2 No Inpatient 2 ER/	Outpatient 3 DOA Other Nursing DOA Time of Injury 28c. Injury at Work?	ng Home 5 Residence 6 Other Scen	9
Division of Vital Records, at or Attending Physician: The law requires after death at Director: After this certificate has been sied in by the funeral director, page 2 should but fifteration: To Be Completed	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Natural 5 Pending	1 Yes 2 No	and a second tree in the second secon	
ivision or Atten after death Director: i in by the	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home,	farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Ro	ute Number, City
Division os Spiral or Attending sours after death meral Director: Aft filled in by the function:	3 Suicide 6 Could not be determined (Specify)		or Town, State)	
Livision of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a Modical Certification: To Be Completed by Physicial				se(s)
To Cor	and manner stated 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Da	ay, Year)
	Theday Il Kind In	O.C.M.E.	September 30, 2006	
	30 Name and address of person who completed cause of death (Item 23a			
	Theodore M. King, Jr., MD. Assistant Medical Exal		e, MD 21201	
Stat Registra	e 31. Date filed (Month, Pay Year) 2006 32 Registrar's Signature	port		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 20, 2006 4:30 A M **Physician** Ruth D. Soldo /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov. | 13, 9. Birthplace (State or Foreign Country)
1915 New York 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F 108-01-1725 90 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County rai', or items 23a or 28e-f ehow Examiner must be nutified at 1₺ Yes 2 No MD Chevy Chase Directo Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20815 4701 Willard Avenue #414 IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) NY State Dept. of Elementary/Secondary (0-12) College (1-4or 5+) other than Civil Service Examinations Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 is marked of traumatic ever 2 William Davton Elizabeth Murtaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 to Department of Health ar Important: If Item 27 is any Injury or other trau 5600 Wisconsin Ave #708 Chevy Chase, MD 20815 Linda Soldo / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 09/22/2006 Washington, DC Oak Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** NEUMONIA /Medical une to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months?
1 Yes 2 No be detached for 4□Pregnant at time of death 5 Other (specify) 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 Yes 1 Yes this certificete 25. Was case referred to medica 26. Place of Death Check only one Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? aral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funaral C Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check o

20

death.

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filed within 72 hours after

Peges 1 and 2 should be nent of Health and Mental

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

9/20/06/9

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature ag

Date filed (Month, Day, Year)

32 Registrar's Signature

2006

d cause of peath (Item 23a) (Type, Print) Celar Lowe 18202A BEHLESON AND 20814

29d. Date signed (Month, Day, Year)

		1		partment of Health and Mertificate of Death	ental Hygien	
	Physicia	an	1. Decedent's Name (First, Middle, Last) Osa McMinn Salter		2. Date of Death September ^{Da}	^{3.} Тіте of Death 11:15Р. м
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital	4b. City, Town, or Location of Death Laure1		c. County of Death Prince George's
244	uneral Director		5. Social Security Number $1 \square M \ 2 \boxtimes F$ 7. Age (In yrs. last birthda $1 \square M \ 2 \boxtimes F$ 91 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year October16	9. Birthplace (State or Foreign Country) 1914 North Carolina
faryland	ehow sd at	70	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Prince George's Beltsvi			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with the N	s or 28a-f	Direct	10e. Street and Number 11374 Cherry Hill Road	10f. Zip Code 20705		itizen of What Country?
5-0036 72 hours after death with the Maryland	ola tygiene. ola other than "natural", or lieme 23a or 28a-1 ehow event, ins Musical Executor musi be notified at	Completed by Funeral Director		3. Was Decedent of Hispanic Origin? (Spull Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc. Specify: White
	al Hygiene. I other than "nature vent, I're Musical E	ompieted	(Specify only highest grade completed) (Gillife Flementary/Secondary (0-12) College (1-4or 5+)	sedent's Usual Occupation re kind of work done during most of work. DO NOT use retired) maker	ng	Kind of Business/Industry
yland 2	nd Mental Hyg marked othe imatic event,	To Be C	17. Father's Name (First, Middle, Last) John McMinn		e (First, Middle, Maide Clingenpee	
Mary d 2 shou	th and M 27 is mar traumati	-		iling Address (Street and Number or Rura Rossmore Drive Bet		
Baltimore, permit Pages 1 an	Department of Health and Menta Important: if Item 27 is marked eny injury or other traumatic events.		20a. Method of Disposition 20b. Place of Discompteny, commetery, commetery, commetery, commetery, commetery, commetery, commetery, commetery, commetery, commetery, commeters, c		Date 20c. I	Location - City or Town, State
Balti	Departm importa eny inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Onald V. Borgwardt 400 Powder Mill Ros	Funeral Ho ad Beltsvi	ome, PA lle, Maryland 20705
Ex.	ysician Medical aminer	iner	23a. Part 1. Enter the disease, or complication that caused the death. Do not estable, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sacuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	ure	or respiratory arrest,	Approximate Interval Between Onset and Death
Records, P.O. Box 68760, The law requires that the death certificate be executed	attending physicien and I for use as the burial-transit	an/Medicai Examiner	that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d. IF FEMALE: 23c. If yes, outcome of pregnancy	3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
P.O. E	by the tached	Physician/M	9 ☐ Unknown	5 ☐ Other (specify)		o use contribute to the cause of death?
rds, a	been signed I should be det	by	Part II. Other significant conditions contributing to death but not resulting in the	s underlying cause given in Part I.		2 X No 3 □ Probably 4 □Unknown
	te hes age 2	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 Å N	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of Vital Physician: T	certifical	o Be	25. Was case referred to medical examiner? 1 □ Yes 2X No Hospital: 1 X npatient 2 □ ER/Outpat	Other	h (Check only one) me 5 - Residence	6 Other (Specific)
₽ ₹	h. After this funeral di	-	27. Menner of Death 14 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injur	of 28c. Injury at	28d. Describe how inj	
S S	ifter deatl Director: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, tte)
To the Hospital	within 24 hours affe To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de (Check only one) 1 Certifying Physician: To the basis of examination and/or and manner stated.			
12	vithin To th comp	Me	29b. Signature and title of certifier 3 'Bava'	29c. License number N 64874	29d. C	oate signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type Shakub Bavan 10724 Lit		way Colon	big, Md. 21044
* *	Sta Registi		31. Date filed (Month, Day Year) 1 2005 32. Registrar's Signature	Sparle	J	

06-07222	stack	Please Type or Print in Black I		rgiene		
boocpii dames e		kawitamend #8 Pestate of Manyland / Department of Health 1-For State Certificate of Death Registrar		Re	g. No. 201	- V
Physicia Medical Exami	:11.77	1. Decedent's Name (First, Middle,Last) Joseph James Stackawitz Jr		2. Date of Deat Month Septembe	h Day Year r 25, 2006	3. Time of Death 1100 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, To	wn, or Location of Death	Соргания	4c. County of De	
Funeral	4	Route 2 and Baltimore Annapolis Boulev Glen B 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under		8. Date of B	Anne Aruno MMM/DD/YYYY) 9.	Birthplace (State or
Director		207–36–3596 1XM 2 F 59 Yrs. Months	Days Hours Min.	Dec. 2		Country) PA
Ŷ.	ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
and show a	ъ	Maryland Anne Arundel Crofton				1 X Yes 2 No
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. Lant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Dire	106. Street and Number 1763 Shaftsbury Avenue	1114	19	og. Citizen of What (United	
ath with reference 2.	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto I		White, et	
after de		1 X Yes 2 No 3 Widowed 4 X Divorced If Yes 1966-1972 1 Yes 2 Or Dates:	X No specify:		Specify: Wh	ite
hours "natura	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual D during most of work	occupation (Give kind of wing life. DO NOT use retire		16b. Kind of Busine	-
5-0036 fled within 72 Hygiene. I other than the Medical	mple	12 Carpenter			Steel M	
21215-0 21215-0 Muld be filed w Mental Hygic marked othe	Be	17. Father's Name (First, Middle, Last) Joseph James Stackawitz	18.Mother's Name Mary Ma	rgaret	O'Toole	
MD 21 d 2 should thth and Me n 27 is ma aumatic ev	٦	19a. Informant's Name/Relationship (Type, Print) Susan Gibson/ Sister 19b. Mailing Address 1763 Shaft	(Street and Number or R Sbury Avenue	tural Route Num e, Crof	ton, MD 2	State, Zip Code) 21114
re, N Ll and Z Health Fitem Z		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State West Arundel C		Date 20	20c. Location - Cit	
Baltimore, bernit. Pages I ar Department of Hee Important: If iter		4 Donation 5 Other Specify:		06	Odenton,	
Baltimo permit. Page Department Important: injury or of	H		0×58007 Was			Services, Inc. 1037
Physician /Medical		23a. Part I. Enter the dise les, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.			est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) Hypertensive atherosclerotic cause (or as a consequence of):	ardiovascular d	isease		Death
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Box 68760, e death certificate be execut the attending physician and ed for use as the burial - tra	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregna	ncy	Month	Day Year
Box death c he atten d for us	ysic	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Special View of the state o	ify)			
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1 of Vital Records ing Physician: The law requi After this certificate has been funeral director, page 2 should	Completed				rmed? deat	
tal Rician: 1	Be C	25. Was case referred to medical	6.Place of Death (Check of Dea		Residence 6 🗸 0	Othor: Seena
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executivithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra		29a Certifier	time, date and place, and opinion, death occurred a	due to the caus	se(s) and manner as and place, and due	started to the cause(s)
To T	Medical	and manner stated. 29b. Signature and title of certifier 29c.	. License number		29d Date signed	(Month, Day, Year)
		Patulionia Blbl -	O.C.M.E.		September 26	6, 2006
		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Re	enn Street, Baltimor	e, MD 2120	1	
	tate					
Regis	ueli	UCI UM SANCORU				

		_	1 - For State Registrar	State of M	aryland / D	epartmer Certificat	nt of He	ealth and Death	Mental H	ygien 2 0	06	31841
*	Physici /Medic		1. Decedent's Name (First, Middle,		SMIT	74			2. Date of D Month Septer	Dav	, ^{Year} 2006	3. Time of Death 6:00 P M
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	e Marylan la-f show	ctor	Maryland 10b. County Anne	Arundel	10c. City, Town	or Location	Davi	dsonvi]	lle			0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with th	Funeral Director	10e. Street and Number 1118 Quince App	le Place		10f. Zip	Code	21035		10g. Citizen o	f What Count	try?
9036	d within 72 hours after death with the Maryland Jene. r then "naturel", or items 23s or 28s-f show the Madical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Marrie 3 WWidowed 4 Divorced	12. Was Decedent Armed Forces? ad 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?	13. Was Dece If Yes, spe	0.000	panic Origin? , Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	lo- 14. Ri Bl	ace - America lack, White, e	etc.
21215-0036	within ane. then "	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	s Education t grade completed) Cotlege (1-4or	5+)	Decedent's Usu (Give kind of wo life. DO NOT u	ork done di ise retired)	uring most of v		16b. Kind of	Business/Ind Financ	
Maryland ?	be file at othe event,	To Be C	17. Father's Name (First, Middle, L Harry T. Barr	_					Name (First, Midde Ma A. Vei		ame)	
	and 2 should balth and Mer n 27 is marke ler traumatic		19a. Informant's Name/Relationsh Melanie Graw/		1	118 Quir	nce A	pple Pl	Rural Route Num Lace Day	vidsonvi	lle, N	4D 21035
Baltimore,	mit. Pages 1 and cardinate of Healt of Healt of Healt octant: If Item 2 injury or other to		20a, Method of Disposition 1 ☐ Burial 2 ☼ Cremation 4 ☐ Donation 5 ☐ Other (Sp.				emato	ry 9/2	Date 21/2006		ore,	Maryland
Balt	permit. P Deportme Importar any injur		21. Signature of Funeral Genyce L	E Al	Oer				John M. : ester St.			MD 21401 Approximate
760,	Physician and hysician and hysician and hysician and he burial-fransit	lical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to or as c.	a consequence of	of):	B	nei	mov	uía		Interval Between Onset and Deeth
.O. Box 68	he death certificat the ettending phy ched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s _i					Date of deliver	ry Day Year
<u>α</u>	The law requires that the de tie has been signed by the e bage 2 should be detached f	þ	Part II. Other significant conditio	ns contributing to death t	out not resulting in	the underlying o	cause give	n in Part I.		I tobacco use co] Yes 2 ☐ No		e cause of death?
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of Vital	ysician: s certific director.	To Be (25. Was case referred to medical examiner? 1 □ Yes 2 □ No		ent 2 ER/Out	tpatient 3 D	OA Othe		Death <i>(Check onl</i>) g Home 5 ☐ Re		sted I	
Division o	Jing After fune	Certification:	27. Manper of Death 1 Matural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide	ation of be 28e. Place of In	iy Year) 28b. T Ir jury - At home, fai tc. (Specity)	njury M		at ? es 2 □No	28f. Location	(Street and Nur.		i Route Number,
	Hospitel 4 hours a Funeral (edical Ce		g Physician: To the best examiner: On the basis of and manyons	of examination and	d/or investigation	n, in my op	inion, death or	corred at the time	e, date and place	e, and due to	the cause(s)
	To the vithin 2 To the c. mple	Me	29b. Signature and title of certifier	2 data	An un,) 29	c. License	number 2/1	138	29d. Date sign	red (Month, L	Day, Year) 70VG MOZIYU
	6		MICHARI J.	completed cause of	my 44	Type, Print)	ENC	EHG.	HWAY +	DNNA	PULSY	MOZIVU
	Sta Regist		31. Date filed (Month, Day, Year) SEP 2	0 2006	rar's Signatura	speck	٠ ·					

State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 3 Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month September 22, 2006 **Physician** Р. м 2:05 Grace Catherine Scott /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St.Marv's St. Mary's Nursing Center Leonard Lowin

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Leonardtown 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 97 Yrs. February 25,1909 Maryland 578-09-7773 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 28a-f show the Medical Examiner must be notified at 1 □Yes 2√TNo Directo St. Mary's Maryland Bushwood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö USA 20618 22685 Maddox Road or Items 23e death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian Black, White, etc. 11. Marital Status filed within 72 hours after Nimed Folces: 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: þ 3 ₩ Widowed 4 Divorced White 'neturel' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) then College (1-4or 5+) Own Home Homemaker Hygier other t permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if Item 27 Is marked othe any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Walter Mattingly Mary Elizabeth Morris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9658 Kline Drive, LaPlata, Maryland 20646 Catherine Louise Binger / Daughter 20b. Place of Disposition (Name of September 20c. Location - City or Town, State 20a. Method of Disposition compteny, crematory or other place)
Charles Memorial
Cardens 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 25, 2006 Leonardtown, Maryland 22. Name and Address of Facility
Mattingley—Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 21. Signatyre of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 2 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral 27. Manner of Leath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21 1)14285 ete cause of death (Item 23a) (Type, Print) 30. Name and address of person who col Dr. William D. Boyd, 25365 Point Lookout Road, Leonardtown, Maryland 20650 Π 31. Date filed (Month, Day, Year) SEP 2 6 Registrar's Signature Registrar

			1 - For State Registrar	State of Maryla		artment of I rtificate of			iene _{eg. No.} 2 0	06	31843
	Physici		Decedent's Name (First, Middle, Last) Annes	s Mary Shaikewi	† ₇			2. Date of Dea Month September	Day	Year N6	3. Time of Death 4:20 P ^M
1.	/Medio Examir		4a. Facility Name (If not institution, give s		02	4b. City, Town, o	or Location of Deat		4c. Count		4.20 F
			Waldorf Health Care Ce	enter		Wald	orf			harles	
	Funeral Director		5. Social Security Number 6. Sex 1 □	7. Age (In y	rs. last birthday) 98 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day Jan. 20,	Year) 1908	9. Birthp Coun Mary	
	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Le	ocation				1	0d. Inside City Limits
	Maryl f ehc	ľo	Maryland Charles	lai	aldorf						1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number	, ,	araor r	10f. Zip Code		1	0g. Citizen of	What Coun	ntry?
	th wit	alD	4301 Young Road			2060	1		USA		
96	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or Itema 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral	1 Never Married 2 Married	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 💢 No		pecify Yes or No- o Rican, etc.)		ce - Americ ick, White, i fv: Wh	
Ö	hours turai'	d be	3 X Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Occur	nation				duetar
Baltimore, Maryland 21215-0036	within 72 ene. than "nai	Completed	(Specify only highest grade		(Give	kind of work done DO NOT use retire	during most of world)	rking	16b. Kind of B		lustry
d 2	Hygi other	Be C	17. Father's Name (First, Middle, Last)			IOHOHUNCI	18. Mother's Nar	ne (First, Middle,			
ılan	Aenta Aenta rked ric ev	ToB	George William Burch				Mary E	: :lizabeth K	nott		
lan	2 sho and h	i i	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ng Address (Street	and Number or Ru	ıral Route Numbei	, City or Town	, State, Zip	Code)
<u>ک</u>	l and fealth im 27 her tr		Rosina Agnes Hall/ Nie			Young Road.	, Waldorf,	_	00-1	O'h T-	0.11
וסר	ages if ite		20a. Method of Disposition 1 XXBurial 2 □ Cremation 3 □ Re	emoval from State	cemetery, cre	matory or other pla	1 000	ober 3,	20c. Location		
틀	artme artme ortant injury		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License		2	morial Gard 2. Name and Addre	ess of Facility		Leonardt	own, Ma	aryland
Ba	Depa Impo any it		Thickard Keira	Hardin	J Ma	ttingley-G	ardiner Fur Leonardic	eral Home	58.A.		
	Physician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the dee cause on each line.	an. Do not en		ng, such as cardia	or respiratory arr		DENT	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):		0 171 -				1 22
	Examine	-	Sequentially list conditions, b.	Due to (or as a cons	ERTER	12:0N					
	s insit	Examlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 03 0 0013	requerice or).						
oʻ	cate be executed obysician and the burial-transit	Еха	that initiated events c. resulting in death) Last	Due to (or as a cons	equence of):						
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9	entifica ling ph e as t	Med	IF FEMALE:								
. Box	death certific e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	3c. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time o	etal death 3	Ectopic pregnanc Other (specify)	у			ate of delive onth	ory Day Year
P. O.	that the di ed by the detached	hys	9 🗆 Unknown	9Ll Unknown							
Vital Records, I	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	by	Part II. Other significant conditions conf	tributing to death but not r	resulting in the u	inderlying cause giv	ven in Part I.	23e. Did to	_	tribute to th	ne cause of death? ably 4 Unknown
ecc	e taw ru has be je 2 shu	Completed						24a. Was a autops	iv /	Were autop	psy findings available mpletion of cause of
<u> </u>		Con						perform 1 Tes	ned?	death?	2□ No
ĬŽ.	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Ott	200	ath (Check only or	•		
	Phys ar this aral di	To To	1 ☐ Yes 2 🗹 No 27. Manner of Death	28a. Date of Injury	ER/Outpatie	II JUDOA	4 priursing F	lome 5 Reside			0
ion	Attending Firdeath. sctor: After by the funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year,) Injury		rk?]Yes 2 ☐ No				
Division of	al or Attendes after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)	reet, factory, office		28f. Location (Si City or Town	treet and Numi n, State)	ber or Rura	I Route Number.
Y,	fo the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my ker: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	, and due to the c irred at the time, d	ause(s) and m ate and place,	anner as st and due to	ated. the cause(s)
U	within 24 To the Fi	ž	29b. Signature and title of certifier	Daul		29c. Licens	se number	2	9d. Date signe	ed (Month, I	Dey, Year)
				13.1			4445	6	SEPT	29	2006
			30. Name and address of person who cor	mpleted cause of death (I	tem 23a) (Type.	Print)	+ 111	L Wald	D. I	MAT	201-02
	Sta	te:	31. Date filed (Month, Day Year)	32 Registrar's Sig	natyre	KIIUII C	1.4102	- 00410	WIT,	NID	20004
	Registr		SEP 2 9 20	UD James	st Age	and a					

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State

Registrar

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2006

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 31845 Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) SEPTEMBER 19 2006 **Physician** 2:50 Daniel Black Thomson /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Mary's Leonardtown St. Mary's Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1**√** M 2□ F Vrs 212-14-5812 85 9/20/1920 Minnesota Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10b. County 10a. State 1 X Yes 2 ☐ No Charlotte Hall Maryland St. Mary's Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20622 Route 2 Box 5 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1942-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Union Carpenter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Heelth end Mental H ent: If Item 27 le marked ott Jean Black James Thomson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24452 Cutsail Drive, Damascus, Maryland 20872 Robert C. Thomson - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Importent: If eny injury or once. Fort Lincoln Cemetery 09/29/2006 Brentwood, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Icenses 4739 Baltimore Avenue, Hyattsville, MD 20781 Albun Inn Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, ox complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of) DAYS. Examiner PNEUMON 1A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of): Examine physiclen and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1) coueNIA · ALZHEMERS 1 Yes 2 No 3 Probably 4 Hnknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Hopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 DNatural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours to the Funerel I 29a. Certifier 社 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9-20-06 D16076 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. RAJBINDER S. GILL PO BOX 640 HOLLYWOOD MD. 20636 31. Date filed (Month, Day, Year) . Registrar's Signature State SEP 2 2 2006 Registrar

		1 - For State Registrar		of Marylan		artmen rtificate				R	eg. No.	11116	31846
Physici		1. Decedent's Name (First, Midd Bertha	lle, Last)	Turran					2	Date of Dear Month Sept.		2006	3. Time of Death 1:30 PM
/Medic Examin		4a. Fecility Name (If not institution	on, give street and no			4b. City,	Town, or	Location o	of Death			County of Death	
Lxaiiiii		Brighton Garde	ens Assist	ed Livin	ıg	Ro	ckvi	11e			Мо	ntgomer	у
Funeral Director		5. Social Security Number 014-38-9742	6. Sex 1 □ M 2 1 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	Min. A	Date of Birth (Month, Day) Lugust	Year)]	9. Birth Con	nplace (State or Foreign untry) MA
land •••		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City	y, Town or Lo	cation							10d. Inside City Limits
Mary	to	MD N	ontgomery	Ro	ockvil	le							1 X Yes 2 ☐ No
or 28	Olrec	10e. Street and Number				10f. Zip				1	-	en of What Co	· ·
ath w 23a	la l	5550 Tuckerman					0852		-1-0 (01	(ited St	
Idfyidhid ZIZID-UUJO 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or lieme 23a or 28e-f ehow aumatic event, the Medical Examinat must be notitied at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rned 1 ∐Yes	cedent Ever in U. Forces? 20 No hive		Was Deced If Yes, spec		spanic Origin, Mexican Specify:	gin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)		 Race - Amer Black, White Specify: 	
TO-UUSO	Completed b	15. Decede	nt's Education est grade completed		16a. Dece	dent's Usua kind of wo	rk done c	turing most	t of working		16b. Kin	id of Business/l	industry
d within giene.	dwo	Elementary/Secondary (0-12)	College 3	(1-4or 5+)			cher				E	ducatio	on
a filed other vent,	BeC	17. Father's Name (First, Middle	, Last)							First, Middle,	Maiden S	Sumame)	
yiand ould be file Menta! Hy wrked oth	일	Joseph Berko	ovitz						ny Ba				
Mary nd 2 sho lth and 27 ls my		19a. Informant's Name/Relation	ship (Type, Print)										^(ip Code) 20852
E, R 1 and Health em 27 ther t		Miriam Cole - 20a. Method of Disposition	Daughter	20b. P	104	01 St	rath	more	Park		#204	N. Bet	thesda MD
eges of of I		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (lace of Dispo emetery, crei aron M			θ) 	9/25/	06		on MA	
permit. Peges 1 and 2 should by permit. Peges 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic enone.		21. Signature of Funeral Service			Ď	Name an anzan	d Addres		_	lemoria	1 Ch	apels]	
10340	-	23a. Enter the disease, o	or complications that	caused the death								MD 2085	Approximate
Physician /Medical		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	each line.	ung Ca								Interval Between Onset and Death
Examiner				o (or as a consequ D	uence of): iabete	s							
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ecuted Ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		yperte	nsion	•						
3 f bU , ate be executed hysician and the burial-transit		rosening in dodain, cast	Due to	o (or as a consequ	uence or):								
08 / 0U, ificate be ex g physician as the buria	dlcal		d										
death cert e attending of for use	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐ Live	utcome of pregna birth 2 Fetal gnant at time of di mown	I death 3	□Ectopic pr □ Other (sp					2	3d. Date of deli Month	ivery Day Year
COTAS, P.O wrequires that the been signed by th should be detache	ρ	Part II. Other significant condit	tions contributing to	death but not res	ulting in the L	inderlying o	ause give	en in Part I		_	bacco u		the cause of death?
NT VI(al MECON hysiclan: The law req his certificete hes beer t director, page 2 shou	Completed									24a. Was a autop perfor	sy med?	prior to death?	itopsy findings available completion of cause of
VITAL siclan: T certificete rector, pa	0	25. Was case referred to medic	al	-				26. Place	of Death	1 Yes Check only or	2 ANO	1 🗆 Yes	25 NO
OT VICA Physiclan: this certific rat director,	To B	examiner? 1 ☐ Yes 2 ☐XNo	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DC	Oth Oth	er: ₄□Nu	ursing Home	e 5 ☐ Resid	lence 6	Other (Spec	Cify) Assisted
ON C		27. Manner of Death 1	28a. Dat ling (Mo tigation	e of Injury onth, Day Year)	28b. Time of Injury	of 2	28c. Injun World 1 🗆	yat k? Yes 2□		d. Describe h	ow injury	y occurred	241216
DIVISION all or Attending s after death. all Director: After ed in by the fune	Certification:	3 Suicide 6 Coul	min and W.B. Pla	ce of Injury - At ho Iding, etc. (Specif	ome, farm, st	reet, factor	y, office		. 28	f. Location (S City or Tow			ural Route Number,
DIN To the Hospital or a within 24 hours after To the Funeral Directory completely filled in E	edical		ing Physici A: To the all Examin . On the and ma										
Within to my	Σ	29b. Signature and title of codif	ier		-		c. Licens 00302	e number 247				e signed (Mont ptember	^{h, Day, Year)} 18, 2006
		30. Name and address of person	n who completed ca MD 5410	use of death (Item Connetic	n 23a) (Type ut Ave	Print) nue #	3 Wa	shing	gton I	C 2001	.5		
Sta Regist		31. Date filed (Month, Day, Yea		Degistrar's Signa									
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	1 - For State Registrar	State of Maryland	-			Mental H		701	06	31847
	1. Decedent's Name (First, Middle, Last) MELVTN C.	TOLSTOT				Month	D		Year 2006	3. Time of Death 7:20 P.M
	4a. Facility Name (If not institution, give s							c. County	of Death	
		7. Age (In yrs. Ii	ast birthday)			s. 8. Date of	Birth			
	579-24-1779 ¹ x	M OFF		Months Days	Hours Mir	Aug.	29,	1923	WASH.	ace (State or Foreign Try) LNGTON , D.C
	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation					10	Od. Inside City Limits
ctor	MARYLAND MONTGOME	RY CHI	EVY CHA							1 XYes 2 No
Dire	10e. Street and Number 2609 BLAINE DRIVE				.5		10g. C			
v Funera	11. Marital Status 1 1 Never Married 2 Married	Armed Forces? 1▼ Yes 2 □ No NAV	lf.	Yes, specify Cu	ban, Mexican, Pue	Specify Yes or nto Rican, etc.)	No-	Black	k, White, e	etc.
ed be		Year or Dates: WW 2	16a. Deced	ent's Usual Occu	pation		16b.			
noiet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give I	and of work done	during most of w	orking				,
S		2 YEARS		SALES	18. Mother's Na	ame (First, Mia	ldle, Maide			3
o Be										
	19a. Informant's Name/Relationship (Typ									
	20a. Method of Disposition	20b. Pl	ace of Dispos	ition (Name of		Date				
b	1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emovat from State		-		0/2006	OL	NEY,	MARYI	AND
SUC.	Donald C.	Stottlemen	L 10	OWARD SA 191 ROCK	GEL FUNE VILLE PI	KE, ROC	KVIL	ON, I LE, M	NC. ARYL	AND 20852
er 🚡	Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a consequ	ience of):						11	
vsician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 ☐ Fetal	death 3 [су					y Day Year
2	Part II. Other significant conditions con	tributing to death but not resu	ilting in the un	derlying cause g	rven in Part I.					e cause of death?
□ □	garkinsan	disecer				a p	utopsy erformed?	d	rior to con eath?	sy findings available apletion of cause of
Be	25. Was case referred to medical examiner?	ospital:		2000	thor			a 🗆 🗆		
ii.		28a. Date of Injury	28b. Time of	3LI DOA	4 PQ Nursing)
rtification	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specity	me, farm, stre	M 1[]Yes 2 □No	28f. Locatio City or	on (Street a Town, Sta	and Numbe	er or Rural	Route Number,
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dical Ce		ician: To the best of my know ar: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the estigation, in my	time, date and place opinion, death occ	ce, and due to curred at the tire	the cause(ne, date a	s) and mar	nner as sta	ated. the cause(s)
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Eriter the disease, or complications that caused they shall. Do not end the mode of dy shock, or heart failure. List only one cause on each line. 25a. Decedent's Equation 1 Gradial Status 26b. Place of Disposition (Name of centre) 27a. Sequentially list conditions, find the past 12 months? 1 Use Signature of Funeral Service Ucensee 10b. Due to (or as a consequence of): 27b. Due to (or as a consequence of): 27c. Due to (or as a consequence of): 27c. Due to (or as a consequence of): 27c. Due to (or as a consequence of): 27c. Due to (or as a consequence of): 27c. Due to (or as a consequence of): 27c. Due to (or as a consequence of): 27c. Due to (or as a consequence of): 27c. Due to (or as a consequence of): 27c. Due to (or as a consequence of): 27c. Due to (or as a consequence of): 27c. Due to (or as a consequence of): 27c. Due to (or as a consequence of): 27c. Due to (or as a consequence of): 27c. Due to (or as a con	1. Decedents Name (First, Middle, Last) 1. 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	Physici		Decedent's Name (First, Middle, II Anna Hamer Tin	-							2. Date of D Month	. D	18 20	06	3. Time of 3:2	A
	/Medic Examin		4a. Facility Name (If not institution, g				4b. City	, Town, or				40	County of C	Death	orge!	3
	Funeral Director					last birthday) Yrs.	If Unde Months	or 1 Year Days		r 24 Hrs.	8. Date of 8 (Month, I	Birth Day, Year	9.	Birthpl Coun	ace (State o	or Foreign
	<u> </u>		Usual Residence of Decedent 10a. State 10b. County			ity, Town or Lo	cation				Feb.	11,	1914		nsylva od. Inside C	
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	h with th	al Dire	10e. Street and Number 7307 Quetzal Dr	rive			10f. Z	p Code	2072	20		10g. C	itizen of Wha		try?	
1 A 036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-f ahow other traumatic avant, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	rces? 2 ∑ No e		Was Decitif Yes, sp	ecify Cuba	lispanic O an, Mexica Specify	an, Puerto	ecity Yes or I Rican, etc.)	No-	14. Race - A Black, N Specify:	Vhite, e		
Anna 21215-0036	within 72 ho ene. than "natur he Medical	Be Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) Coltege (1	-4or 5+)	16a. Dece (Give life.	kind of w	ork doné o use retired	during mo	st of work	ing		Kind of Busin		,	_
ار اand 2	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 ia marked other than any injury or other traumatic avent, the Means injury.	To Be Co	17. Father's Name (First, Middle, La William Hamer	st)			CICL	ICUI			e (First, Midd e Maud	le, Maide		O V C.	CIRCII	-
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iore,	Pages 1 ar nent of Heal ant: if item 3 ury or other		20a. Method of Disposition 1区域urial 2	☐Removal from S	20b.	Place of Dispo cemetery, crer kemont	matory or	other plac			Date 1 /2006		ocation - Cit			,
$\overline{I/m}\mathcal{C}h\mathcal{L}'_{l}$ Baltimore, Maryland	permit. Pa Departmen Important any injury		4 Donation 5 Other (Spe 21. Signature uneral Service Lice		10	22	2. Name a	nd Addre	ss of Faci	lity JO	hn M	Taylo	or Fun nnapol	era	L Home	9
	Physician /Medical		23a. Part1. Enter the disease, or conditions and the condition of the condition resulting in death)	ly one cause on ea	aused the dea ach line.	th. Do not ent	ter the mo	de of dyin	ng, such a	s cardiac		arrest,			Approximat Interval Bel Onset and	te ween Death
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.O. Box	Attanding Physician: The law requires that the death certific death. ector: After this certificete hes been signed by the attending by the funeral director, page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		inth 2 ☐ Feta ant at time of	aldeath 3□	∃Ectopic ∃Other (s	oregnancy specify)	′			-	23d. Date o Month		-	Year
rds, P.	quires that in signed b		Part II. Other significant conditions	s contributing to de	eath but not re	sulting in the u	nderlying	cause giv	en in Part	11.	1	d tobacco	use contribu	te to th		death?
I Reco	ding Physician: The law re h. After this cartificate hes bee funeral director, page 2 sho	Completed									24a. Wh au pe 1 ☐ Yes	topsy rformed?	prio dea	rtocon th?	sy findings apletion of a	available ause of
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Division of Vital Records, P.O. Box	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af	Certification:	2 Accident investigal 3 Suicide 6 Could no 4 Homicide determin	ion		nome, farm, str	M reet, facto	1 🗆	Yes 2			(Street a	and Number o	or Rura	Route Nun	nber,
_	a Hospita 24 hours a Funeral letely filled	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the eminer: On the ba and mann	asis of examin	owledge, deat ation and/or in	h occurre vestigatio	d at the tir n, in my o	ne, date a pinion, de	and place, eath occur	and due to the	ne cause(e, date ar	s) and manne nd place, and	er as st due to	ated. the cause(s	s)
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	, [30. Name and address of person w	no completed caus	e of death (Ite	m 23a) (Type,						ţ	ı			
	Sta		Dr. Moustafa 31. Date filed (Month, Day, Year) SFD 2 (32.	5/5 Ma egistrar's Sign	ain St.	Su	ite 3	551	Laur	cel, Ma	iryla	ind 20	706		

Baltimore, Maryland 21215-0036

	•	1 - State Registrar					Cen	ificate o	f Deat	th		Reg. No				
	i.	Decedent's Name (First, Middle	e, Last)								2. Date of				3. Time o	f Death
Physicia		Carol Jean Ten	11037								Month	Da ombor	23,20	ear 106	1:30	Λ M
/Medic:		4a. Facility Name (If not institution		eet and ni	ımber)			4b. City, Town	or Locatio	on of Death			. County of		1:50	A
Examine	r			001 2270 110	,,,,,								-		***	
		43832 Palamino Da 5. Social Security Number	6. Sex		7 400 (In yrs. last b	irth da v	Holly If Under 1 Yes		der 24 Hrs.	8. Date o		Saint		ys lace (State	or Foreign
Funeral		•	1 🗆	M 2 KF		2	Yrs.	Months Day			(Month	, Day, Year)		Coun	try)	
Director		220-42-0976 Usual Residence of Decedent			0	12					July	6, 1944	V	lasn1	ngton,	р.с.
and *	1	10a, State 10b. County			1	Oc. City, Tov	vn or Loc	ation						1/	0d. Inside C	City Limits
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or S	Funeral Director	10e. Street and Number						10f. Zip Code				10g. Cr	tizen of Wha	t Coun	try?	
23e	g .	43832 Palamino	Dr	Lve				20	636				USA			
eb	Ine	11. Maritai Status		2. Was Dec Armed F	edent Eve orces?	er in U.S.	13. W	as Decedent of Yes, specify C	of Hispanic uban, Mexi	Origin? (S can, Puert	pecify Yes o to Rican, etc.	r No-	14. Race - Black, 1			
or it	Ĭ	1 X Never Married 2 Mar		1 ☐ Yes If Yes, G	2 X No ive		1	☐ Yes 2XIN	lo Spec	eity:			Specify:	Whi	te	
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al Hy	Be	17. Father's Name (First, Middle,	,						18. Mo	other's Nan	ne (First, Mic	ddle, Maider	Sumame)			
Aent Aent rkec tice	0	Andrew Charles	Ten.	Ley					M	laria	nna Ha	rmon				
sho ma uma		19a. Informant's Name/Relations	hip (Typ	e, Print)		19	b. Mailing	Address (Stre	et and Nur	nber or Ru	ıral Route Nu	ımber, City	or Town, Sta	te, Zip	Code)	
nd 2 alth a 27 is	1	Constance Stein	nel/	Exect	utor	43	3832	Palami	no Dr	ive I	Hollyw	ood, N	D 206	36		
Heg tem othe		20a. Method of Disposition				20b. Place	of Dispos	ition (Name of		1	Date	20c. L	ocation - Cit		wn, State	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, 1.a Moulcal Exaction trial to incitified at once.		1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		moval from	State			atory or other p orial Ga:			ember 2 2006		nardtor	7+0 N	fawri 1 an	A
rtme rtan njur		21. Signature of Funeral Service		17		Charte	-	Name and Add	-	1	2000	Leo	nardtow	11, 11	aryran	u
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*	- 1	23a. Party. Enter the disease, or shock, or heart failure. List	only one	cause on	each line.		_				c or respirato	ry arrest,		- 1	Interval Be Onset and	tween
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/Medical		resulting in death)		Due to	(or as a c	onsequence	of):					- 0 0	-00		7 2	- a h
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0 0 0	3	IF FEMALE:	23	c. If yes, ou	utcome of	pregnancy							23d. Date o	f delive	erv	
atter	clar	23b. Was decedent pregnant in the past 12 months?				Fetal death		Ectopic pregna Other (specify)					Month			Year
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hat t	Completed by Physician	Part II. Other significant conditi	ons cont	nbuting to	death but r	not resulting	in the un	derlying cause	given in Pa	art I.	23e. [Did tobacco	use contribu	ite to th	e cause of	death?
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Phy or thi		27. Manner of Death		28a. Date	of Injury	28b.	Time of	28c. lr	njury at	, reading t		ibe how inju		- Doony	/	
ding h. Afte	Ē	1 Natural 5 Pendir	ng igation	(Moi	nth, Day Y	'ear)	Injury	V	Vork? □Yes 2	No						
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To the Hospital or Attending Physicien: The taw within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	ပိ	no Contine (Months)	- Db	-1 T. II			- 4									
Hos 4 ho Fun Fun tely f	edical	(Check only 2 Medical	Examin	er: On the I	basis of ex	camination a	je, death nd/or inv	occurred at the estigation, in m	y opinion,	and place death occu	e, and due to urred at the ti	the cause(s me, date an) and mann d place, and	∍r as st I due to	ated. the cause((s)
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Y		30. Name and address of person	who con			th (Item 23a)	(Туре, Р	rint)	0 = = 1	nr)	11311	220	_	0	.01
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Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 Sept 20, **Physician** 6:25 a Josephine Madeline Viana /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heartland Nursing Home Prince George's Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country)

Dec. 21, 1925 Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 80 578-24-3247 Director Usual Residence of Decedent 2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene.

Is marked other then "natural", or Items 23a or 28a-f ehow 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other then "natural", or Items 23a or 28a-f ehow other treumatic event, the Madical Examinar must be notified at 1 X Yes 2 ☐ No Directo Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5415 Ruxton Drive 20706 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Geier Madeline Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 James Oliver - Son 5415 Ruxton Drive, Lanham, Maryland 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of himportant: If its eny injury or of once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) Fort Lincoln Cemetery 09/23/2006 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 20781 4739 Baltimore Ave., Hyattsville, MD Many Approximate Interval Between Onset and Death 23d. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1-AR DIOPULMONARY **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physician and s the burial-transit IGESTIVE that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical use as igned by the ettending be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2 No 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 VNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred After t 1 Matural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD SEPTEMBER 21, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMYESIAKA HORSEOVER PARKWAY GREGORBELT MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene State
Registrar #5 per FH/wichd/10-3-06/d1s Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Katherine R. Victor September 21, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 🕱 F Yrs. Director 101 Oct. 14, 1904 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show other traumatic event, the Medical Examinar must be nutified at 1 ☐ Yes 2 X No Director Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Gull Creek 1 Meadow Street 21811 U.S.A. 232 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 275 No Specify: Specify. 3XWidowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be n and Mental I 2 John Widgeon Lucy Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Henman (niece) 8458 Langmaid Road Newark, MD 21841 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 = 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park | 09-23-2006 Berlin, Maryland 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee Delmar, DE 19940 13 E. Grove Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardral 148 hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Doe to (unas a consequence of) requires that the death certificata be executad Due to (or as a consequence of): 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Year Month Day 5 Other (specify) 4 Pregnant at time of death Ö ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 ☐ Yes Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To of this ht80-ht 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Division Natural 5 Pending death. 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide -412 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0064428 nd address of person who completed cause of death (Item 23a) (Type, Print) 9733 Healthway Orive Szymala DO Jason 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **SEP 22** 2006 Registrar

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Katherine

			1 - State Registrar	State of Maryland			of Health a of Death	and Me		_	2006	31852
H	Physici	an	Decedent's Name (First, Middle, Last					2	Month Per	ath Day	Year Year	3. Time of Death
H	/Medic	al	Frieda 4a. Facility Name (If not institution, give	Voge1		4b City Toy	n, or Location of		ept. I		2006 County of Death	9:45 PM
	Examin	er	Collingswood Nur				ville	Doain			lontgome	
	Funeral Director		5. Social Security Number 6. Se 065-12-8419	x 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Y Months Da		Min.	B. Date of Birt (Month, Da lay 5,	th y, Year)	g. Birth	hplace (State or Foreign untry) NY
			Usual Residence of Decedent					11.	14, 5,	1722	_	
	arylar show	<u>_</u>	10a. State 10b. County		, Town or Lo							10d, Inside City Limits X□ Yes 2□ No
	the M	ecto	MD Mon	tgomery Ga	aither	sburg 10f. Zip Co	de			10a Citi	zen of What Co	
	3a or	Funeral Director	9836 Dellcastle Ro	ad		101. 2.0	20886		-	-	United S	•
	death	nera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent	of Hispanic Orig Cuban, Mexican,	gin? (Speci	rfy Yes or No	-	14. Race - Amer Black, White	
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7	ithin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use n	etired)	or working	•			
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an an	uld be f dental l rked of tic eve	To Be	Isador Meinber	g							einberg	
Maryland 21215-0036	d 2 sho th and I 7 is ma frauma		19a. Informant's Name/Relationship (7) Steven A. Vogel -				reet and Number astle R					
<u>စ</u> ်	s 1 an I Heal Item 2		20a. Method of Disposition	20b. P	ace of Dispo	sition (Name o	of spinon	Da	te	20c. Lo	cation - City or	Town, State
Ë	A in the same of t		1 X Burial 2 ☐ Cremation 3 X 4 ☐ Donation 5 ☐ Other (Specify)	10moval from State	-	-		9/21/	06	Gra	anville	Twp. PA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tier az is marked other then "natural" or Items 23a or 28a-f show eny injury or other traumatic event. The Medical Examinar must be notified at once.		21. Signature of Funeral Service Licens	500			ddress of Facility					
			23a. Part1. Enter the disease, or comp	lications that caused the death			kville dying, such as d				MD 2085	Approximate Interval Between
	nysician:		shock, or heart failure. List only o Immediate Cause (Final disease or condition		lnutr	ition					13	Onset and Death
	/Medical Examiner		resulting in death)	a Due to (or as a consequ De	ence of):	ion						
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ds, P	es tha gned be de	by	Part II. Other significant conditions co	ntributing to death but not resu	ilting in the ur	nderlying caus	e given in Part I.				_	the cause of death?
ဝို	law requir as been si 2 should	piete							24a. Was		24b. Were au	topsy findings available
r	The ate h page	Completed							autop perfo 1 Yes	rmed? 2 🔯 No	death?	topsy findings available completion of cause of
VIE	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:			0.1		Check only o			
5	Phys rthis eral dii	: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of		Injury at Work?		e 5 🗌 Resid		6 □Other (Spec	cify)
ö	Attending Physician: or death. sctor: After this certific by the funeral director.	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ N	No				
Division	a # F =	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, of	fice	28	8f. Location (S City or Tox	Street and vn. State	d Number or Ru)	ral Route Number,
	To the Hospital or Attend within 24 hours after death To the Funars! Director: 4 completely filled in by the fi	Medical (29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of my knowiner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the	ne time, date and my opinion, deat	d place, an th occurred	d due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		/	29c. Li	cense number			29d. Dat	e signed (Monti	h, Day, Year)
	D		a. Slice	dman;	ma	D3	7801		S	Septe	ember 20	, 2006
1			30. Name and address of person who co			•	.	000 =		1 -	D 000F5	
	Sta	te	A. Seidman 31. Date filed (Month, Day, Year)	MD 15020		~40	Road #:	300 R	ockvil	⊥e M	ш 20852	<u>′</u>
	Registr			106 America A	7. 60	346.5						

		1 - For State Registrar AMEND#19bperFH	State of Marylar 9/21/06,BW,McCo		artment of He rtificate of D		R	leg. No. 2	006	3185
Physicia /Medic	al		oatrick	Vi	ckerie	anation of Canti	2. Date of Dea Month September	n 15	Year 2006 nty of Death	3. Time of Death
Examin Funeral Director	er	4a. Facility Name (If not institution, give to the Johns Hopkins 5. Social Security Number 578-94-3199	Hospital	last birthday) Yrs.	Baltimore If Under 1 Year Months Days	City If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day APRIL 29.	Year)		* -
	or	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or La			MINIB 27	, 1,,,,		0d. Inside City Lim
a or 28a- be notif	Director	MARYLAND PRINCE GEO 10e. Street and Number			10f. Zip Code		1	10g. Citizen o		itry?
ilal Hygiene. od other than "natural; or Items 23e or 28e-f ehow event, Ina Medical Examinar must be notified at	by Funeral	1011 WINGED FOOT DRI 11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	VE 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		2072: Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☒ No		pecify Yes or No- o Rican, etc.)		S.A. ace - Americ lack, White, city:	etc.
al Hygiene. I other than "natur: vent, the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation a completed) College (1-4or 5+)	(Give life. I	dent's Usual Occupation of work done of the old of work done of the old of the old of the old old old old old old old old old old	ring most of wor	king		Business/Ind	dustry
and Mental Hyg Is marked other raumatic event,	To Be C	17. Father's Name (First, Middle, Last) GEORGE VICKERIE				18. Mother's Nar	ne (First, Middle, YARRIS	Maiden Sum	ame)	
atth and 27 is n er traun		19a. Informant's Name/Relationship (Ty, KAREN VICKERIE - SP		1011 1	ng Address (Street ar Winged Foot LNGED FOOT: D	ot Dr. M	itchellv	ille.	MD 207	
Department of Health and Menta Importent: If Item 27 Is marked eny injury or other traumatic evonce.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crem T LINCOL	sition (Name of matory or other place N CEMETERY	9/25	Date 5/2006	20c. Location BRENTWO		
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hysicien and strength by sicien nd strength by sicin and strengt	Examiner	234. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Supernitary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec Hepatore Due to (or as a consec Hepatocel Due to (or as a consec Hepatocel Due to (or as a consec	quence of):	ndrome carcinoma	such as cardiac	correspiratory arr	est,		Approximate Interval Between Onset and Death 3 days 6 months 40 years
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been signed should be de	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause giver	in Part I.	23e. Did to			e cause of death
page 2	e Completed	25. Was case referred to medical						med? 2,200 No	prior to cor death? 1 \(\sum \text{Yes}\)	psy findings availant pletion of cause 2 No
S E	To B	examiner?	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	t 3 DOA Other	4 🗌 Nursing H	ith (Check only or lome 5 Reside 28d. Describe he	ence 6 🗆 C		')
within 24 hours after death. To the Funerel Director: After it completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	fy) 			28f. Location (S. City or Town	n, State)		
in 24 hor the Fune pletely fi	Medical	(Crieck only 2 ☐ Medical Examin one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inv	n occurred at the time vestigation, in my opi	, date and place nion, death occu	, and due to the c irred at the time, d	ause(s) and i late and place	manner as st e, and due to	ated. the cause(s)
Tot	Σ	29b. Signature and title of certifier Tustin Bachman			29c. License Res -	000	5	29d. Date sign	er 15	2006
Sta Registr		30. Name and address of person who co Justin Bachmann, The 31. Date filed (Month, Day, Year) SEP 2 1 20	Johns Hopkas I	tosa) (1900,	600 North W	rolfe Stree	f, Bultimore	e Mor	yland	21287

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			For State Registrar	State of Marylan			nt of He <i>te of E</i>			giene 🛰 ` Reg. No.	000	2103
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Evelyn P.	V	Vilson				2. Date of De Month SEPTEM	Day	Year 2006	3. Time of Death 0400 M
	Examin		4a. Facility Name (If not institution, give st Memorial Hospital	reet and number)			, Town, or berla	Location of Death		4c. Count	y of Death .egany	
	Funeral Director		214-03-3302	7. Age (In yrs. 90	last birthday) Yrs.		er 1 Year Days	Hours Min.	8. Date of Bir Month, Da Apr 2	, 1916	9. Birthp Cour	lace (State or Foreign
	Aaryland	ō	Usual Residence of Decedent 10a. State 10b. County MD Allegan		y, Town or Lo	berla	and				1	0d. Inside City Limits 1 XYes 2 No
,	with the Assort 28a-	Direct	10e. Street and Number 1925 Frederick Stre	eet		10f. 2	ip Code	21502		10g. Citizen of	What Cour	ntry?
920	be filed within 72 hours after deeth with the Maryland thygiene. All this natural, or iteme 23a or 28a-f ehow do other than "natural," or iteme 23a or 28a-f ehow event, tra Medical Examinar must be notified at	by Funeral Director		2. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			edent of His ecify Cubar 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ice - Americ ack, White,	etc.
121	filed within 72 ho Hygiene. ether than "natur. ant, tre Medical I	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece (Give life. Bookk	kind of v DO NOT		tion uring most of work	ing	16b. Kind of B		dustry
land;	ihould be filed in Mental Hygie marked other matic event, III	To Be C	17. Father's Name (First, Middle, Last) Leslie Hinkle					18. Mother's Nam Eva Ma	e (First, Middle ae (Perri			
	nd 2 sh lith and 27 is m r traum		19a. Informant's Name/Relationship (Type Margaret VanGelde	e, Print) er sister	19b. Mailie 192	ng Addre	ss (Street a ederic	nd Number or Rui k Street	ral Route Numb Cum	er, City or Town berland	n, State, Zip MI	21502
more			20a. Method of Disposition 1		Place of Dispo cemetery, crei nset Mei	natory o	other place		Date 10/3/2006	20c. Location		
Balt	permit. Page Department of Important: If any injury or once.		21. Signaturije of Funeral Service License	Scarpell	4	1	08 Virg	i	e: Cumbe		21502	2
✓	Cale be executed Medical Medical Txaminer transit The privative and the privativ	Examiner	23a. Part 1. Enter the disease, or complete shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection)	uence of):		-	Diseas			5	Interval Between Onset and Death Y Cars
P.O. Box 68760,	The law requires that the death certificate bite has been signed by the attending physicage 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregni 1 ☐ Live birth 2 ☐ Fela 4 ☐ Pregnant at time of c 9 ☐ Unknown	Ideath 3	⊒Ectopic □ Other (pregnancy specify)				ate of delive	ery Day Year
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		Completed			-						. Were auto prior to co death? 1 \(\sum Yes	psy findings available mpletion of cause of 2 \square No
Vital	Physician: r this certific ral director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 npatient 2] ER/Outpatier	nt 3□	Othe	26. Place of Dea	th <i>(Check only o</i> ome 5 ☐ Resi		ther (Specif	(v)
	g e		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury Work			how injury occu		,,
Division	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the funeral completely filled in by the funeral completely filled in by the funeral completely filled in the funeral c	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st fy)	reet, fact	ory, office		28f. Location (City or To		nber or Rura	al Route Number,
	• Hospit 124 hours • Funera letely fille	Medical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurre vestigati	ed at the tim on, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s) and n date and place	nanner as s , and due to	tated. o the cause(s)
)	To the vithing comp	Ň	29b. Signature and title of certifier				9c. License	number		29d. Date sign		Day, Year)
	6		30. Name and address of person who con			Print)		ruland o	1502			
	Sta Regist		Vik Poonai M.D. 924 31. Date filed (Month, Day, Year)	32. Registrar's Signa	aturo -	rian		ryranu Z	1304			

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			For State Registrar	State of N	/larylan			nt of H ete of L			ental H	ygien Reg. N	/ [] [06	3 1	855
\$1. \$1.	Physici /Medic		1. Decedent's Name (First, Middle, La	151)		West	n. n	fin			2. Date of Month SEPTE	D	21,	Year 2006		e of Death 25A M
	Examir		4a. Facility Name (If not institution, given				4b. 9	y, Town, or		of Death		4	c. County			
	74.	, i.	PRINCE GEORGES H		ENTER	last birthday)	If Und	CHEV	ERLY If Under	24 Hrs.	8. Date of	Birth	PRIN		GEORG	
	Funeral Director			XX M 2□ F	190 (117) 73.	73 Yrs.	Month		Hours	Min.	(Month, DEC. (Day, Yea	932	Cour	RGINI	te or Foreign
			Usual Residence of Decedent								, LO.	,,,,,,,	. 7 5 2			
	ehow	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							1		e City Limits Yes 2 ☐ No
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	with ti	D I	10e. Street and Number	A.D.			10f. 4	Cip Code	7				Citizen of W			
	leath ns 23	Funeral Director	4730 LAKELAND RO.	12. Was Deceder	nt Ever in U	.S. 13.	Was Dec	2074		igin? (Spe	cify Yes or		JNITEI 14. Race		an Indian	١,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23e or 28e-f ehow any Injury or other traumatic event, the Medical Exercision must be notified and once.	þ	1 ☐ Never Married ※※ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force: 1 Yes X If Yes, Give Year or Dates	s? <mark>X</mark> No			ecify Cuba	n, Mexicar Specify:	n, Puerto F	cify Yes or Rican, etc.)		Specify:	k, White,		
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and	d be f antal h	Be c											or corrain	,		
Maryland	should nd Men marke umatic	ဥ	LINDSEY WASHINGT 19a. Informant's Name/Relationship			19b. Maili	ng Addre	ss (Street a			E CRUN		or Town,	State, Zip	Code)	
	and 2 ealth a n 27 Is		ROMONA WASHINGTO	N / DAUGH	TER	822 1	HR D	RIVE,	SE	WASH	HINGTO	ON, I	C 200	32		
ore,	of Hei		20a. Method of Disposition 1 ☐ Burial XX Cremation 3 [Domewal from Stee		Place of Disposemetery, cre	osition (A	ame of	е)	D	ate	20c.	Location -	City or To	wn, State	э
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Baltimore,	permit. Departr Imports any Inji		21. Signature of Furnance Service Licensee 22 MARSHALLES STEWNERAL HOME OF 4308 SUITLAND ROAD SUITLA									INC.				
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P.O. Box	The law requires that the deeth certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Il death 3	⊒Ectopic ⊒ Other (pregnancy (specify)				-	23d. Date Mor		ery Day	Year
	es that igned b be deta	by Pł	Part II. Other significent conditions	contributing to death	but not res	sulting in the u	ınderlyinç	cause give	en in Part I		23e. Di	d tobacco	use contr	ibute to t	ne cause	of death?
rds	w require been sig should b	ed	DIABETES MELLIT	US							1[Yes	2 🗌 No	3 Prob	ably X	Unknown
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no	Jing After fune	ion	XXNatural 5 ☐ Pending	28a. Date of Ir (Month, L	Day Year)	Injury	м	28c. Injury Work			8d. Describ	e now in	jury occurre	90		
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			Mad Y	W/	N/T)			1)4	1606	>		<u> </u>	71.7.	110	6	
R	(3)		30. Name and address of person who		f death (Iter			-m	\D T T T	OHEN	/EDT 57	M	20705			
/	-		NADER DAKAK, M.D 31. Date filed (Month, Day, Year)		strar's Signa	3001 I		LIAL I	JKTVE	CHE	/ LKLY,	MD	20/85)		
	Sta Registr		CED 2 5 2086	Maria	. 1	ature	el.									

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	Dhuaisic		Decedent's Name (First, Middle		CI DI.						2. Date of Dea	ath		3. Time of [
	Physicia /Medic		Sara Alice Win								Septemb		2006	2:50p) М
	Examin	er	4a. Facility Name (If not institution Ravenwood	_			4b. City, Tov Hager			f Death			ty of Death		
	Funeval		5. Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Y	/ear	If Under		8. Date of Birt		hingto 9. Birthp	lace (State or	Foreign
	Funeral Director		219-14-9238	1 ☐ M 2X F	74	Yrs.	Months D	ays	Hours	Min.	8. Date of Birt (Month, Da 05/20/1	v, Yea <i>r)</i> L932	Coun	PA	
	bu >		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	postion						11	0d. Inside City	v Limits
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	the A	rect	10e. Street and Number				10f. Zip Co	ode				10g. Citizen of	What Coun	itry?	
	h with	Funeral Director	1306 Potomac A	venue, #2	1 A		21	1742	2			US			
	ems ?	ner	11. Marital Status	12. Was Dece	edent Ever in U.S. prces?	13.	Was Decedent	t of His Cuban	panic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	14. Ra	ce - Americ		
36	s afte , or it	by Fu	1 ☐ Never Married 2 ☐ Marr 3 🛣 Widowed 4 ☐ Divorced	ied 1 ☐ Yes If Yes, Gir Year or D	ve		1 ☐ Yes 2 🛣		Specify:			Spec	ity: Wh	ite	
9	2 hour	edt	15. Deceden	t's Education		16a. Dece	dent's Usual O)ccupat	tion			16b. Kind of	Business/Ind	dustry	
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and	tbe fil ntal H ed otf	Be	17. Father's Name (First, Middle, Ephraim Glenn	•							lizabetl				
Ž	should nd Me mark imatic	ှင	19a. Informant's Name/Relations			19b. Maili	ng Address (Si	treet ar			al Route Numbe			Code)	
Baltimore, Maryland 21215-0036	and 2 alth a 27 is er trau		Esta M. Barton	/ Sister		300	0 Great	t Co	ove R	Road,	, Warfoi	dsburg	, PA :	L7267	
ore	of He of He if Item		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from	State cen	netery, cre	osition (Name of matory or other	r place			Date	20c. Location			
ţi	Pag tment tant:		' 4 □Donation 5 □ Other (S	pecify)	Antic	_					7/2006				
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examinat must be notified at once.		21. Signature of Funeral Service	Licenson							cald N. eet, Hag			_	ome
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ERT n of	ding Pt ,r After th funeral		27. Manner of Death 1 Natural 5 □ Pendir 2 □ Accident investi	9	of Injury 2 th, Day Year)	8b. Time o		. Injury Work			28d. Describe I	now injury occu	urred		
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11:50 AM William Herbert Weibley, Sr. September 20, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 23, 1948 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1໘M 2□F 57 Director 161-40-1443 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rthan "natural, or iteme 23a or 28a-f show the Medical Examinar must be notified at Director PA Franklin Shippensburg 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 Howard Avenue 17257 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed v Depertment of Health and Mental Hygie. Important: If item 27 is marked other til eny injury or other traumatic event, that once. 12 Clerical/Warranty Dept. Mack Trucks, Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Weibley Elizabeth J. Perry ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ilona D. Weibley/Wife 16 Howard Ave., Shippensburg, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Parklawns Memorial Gardens 9/25/06 Chambersburg, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.L. Davis Funeral Home Jeffer LE DAVIS MO1414 12525 Bradbury Ave., Smithsburg, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death ntra Coming Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed hes been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificete 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 ER/Outpatient 3 DOA this Funarai Director: After thately filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicul Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check unit) Vithin 2 To Los 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60228 September 22 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown Mary Ahmed 12821 31. Date filed (Month, State Registrar

			1 - State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment c rtificate	f Health ar of Death	nd Mei	ntal Hyg	giene 0	06	31858	
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100 M	Funeral Director		444-22-2464 Usual Residence of Decedent	7. Age (In yrs. la 82		Months Da		Min.	(Month, Day	7, Year) 80,1924		alace (State or Foreign atry)	
	the Marylar 28a-f show	Director	MD Anne Aruno 10e. Street and Number		.Town or Lo		10			10g. Citizen of		0d. Inside City Limits 1 Tyes 2 No	
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036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itlem 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Macified Examinat must be notified at	by Funerai	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 A No If Yes, Give Year or Dates:		Was Decedent f Yes, specify 1 ☐ Yes 2 🛣	of Hispanic Origin Cuban, Mexican, I No Specify:	n? (Specify Puerto Ric	y Yes or No- an, etc.)	14. Rai Bla	ce - Americ ck, White, by: Whi	etc.	
Baltimore, Maryland 21215-0036	within 72 ho iene. then "natur	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	(Give life. l	dent's Usual O kind of work d DO NOT use re	of working		16b. Kind of Business/Industry					
and	d be filed antal Hyg sed other c event,	Be	17. Father's Name (First, Middle, Last) John	Thompson			18. Mother's			Maiden Sumai	me)		
Mary	12 should and Me 7 is mark	2	19a. Informant's Name/Relationship (Type Wayne Williams				reet and Number	or Rural R		r, City or Town	, State, Zip	Code)	
more, I	Pages 1 and nent of Healt int: If Item 2: iry or other i	Wayne Williams Husband 20a. Method of Disposition 1								· City or To			
Balti	permit. Pages Department of Important: If It eny injury or once.		21. Signature of Fungral Service Licenses	-			funeral						
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O. Box	in the past 12 months? I □ Live birth 2 □ Fétal déath 3 □ Ectopic pregnancy I □ Yes 2 □ No 1 □ Pregnant at time of death 5 □ Other (specify)								Date of delivery Month Day Year				
								0	co use contribute to the cause of death?				
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	Physicien: rthis certific ral director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 Inpatient 2 E	B/Outnation	t 3 DOA	04		heck only o		ner (Snecif	u)	
	Afte		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation				28d	ne 5 Residence 6 □ Other (Specify) 28d. Describe how injury occurred					
Division	p # F =	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, str	eet, factory, of	ice	28f.	Location (S City or Tow		ber or Rura	l Route Number,	
	5 4 7 5 5 4 2 5	Medical	29a. Certifier 1 Pecertifying Physic (Check only one) 2 Medical Examine	cian: To the best of my know er: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the vestigation, in i	ne time, date and my opinion, death	place, and occurred	I due to the d at the time, d	cause(s) and m date and place,	anner as s and due to	tated. the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	3	^	ļ.	cense number	2		29d. Date signe			
			30. Name and address of person who com	pleted cause of death (Item	23a) (Type	Print)	3856.	3		epient	ser 20	0, 2006 0 20 M	
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			For State	State of Marylar					7111	6 31859			
			Registrar		Cei	rtificate of L	Jeath		ig. No				
н	Physicia	an	Decedent's Name (First, Middle, Last					2. Date of Death Month	Day	3. Time of Death			
	/Medic	al	William Paul Wes	06 1720 M									
*	Examin	er	4a. Facility Name (If not institution, give	street and number)	nin	4b. City, Town, or	Location of Death	1	4c. County of				
			COHSTAL HOSPI	CE AT THE L	AKE	SAUS	DUKY If Under 24 Hrs.	Done of Bish	2 - 6	9. Birthplace (State or Foreign			
	Funeral		1	Months Days Hours Min. (Month, Day, Year)									
	Director		579-26-0831 Usual Residence of Decedent	80				March 4,	1926 W	ashington, DC			
	land		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation		-		10d. Inside City Limits			
	Many f • h	ō	Florida Lee	Tr.	ort Mye					1 ☐ Yes 2 🔀 No			
	the 288-	Director	10e. Street and Number	PC	or c riye	10f. Zip Code		10	Og. Citizen of Wi	nat Country?			
	with the or		12900 Kelly Gre	ens Blvd.			33908			USA			
	death with the Maryland ms 23s or 28s-f show	era	11. Marital Status	12. Was Decedent Ever in U	I.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-	14. Race	- American Indian,			
0		Funerai	1 Never Married 2 Married	Armed Forces? 1⊈TYes 2 ☐ No				o Hican, etc.)		, White, etc.			
ğ	hours after lural', or Ite	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: WWI]		1 ☐ Yes 2½ No	Specify:		Specify:	White			
21215-0036	72 ho	Completed	15. Decedent's Ec		16a. Dece	dent's Usual Occupa	ation during most of war	kina	16b. Kind of Bus	iness/Industry			
2	filed within 72 Hygiene. wher than "nai	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)						
21	or th	5	12		V	ice Presi				ing/Appraisal			
2	be file	Be (17. Father's Name (First, Middle, Last)					ne (First, Middle, M					
<u>s</u>	2 should be and Mental Is marked o	ဥ	Ralph A. Weschl	er, Sr.			N	Mary Luci	le Edel	en			
Maryland	and and ls m	8 3	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a	and Number or Ru	ral Route Number,	City or Town, S	tate, Zip Code)			
2	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny Injury or other traumatic engine.	1 (Esther G. Weschl			Këlly Gr	ecrs blv						
Baltimore,	of H of H or oth	11 9	20a. Method of Disposition 1 St Burial 2 ☐ Cremation 3 ☐		Place of Dispo cemetery, cre	osition (Name of matory or other plac	e) Sent	Date 25,	20c. Location - C	City or Town, State			
Ĕ	Pag ment ant: ury c		4 ☐ Donation 5 ☐ Other (Specif		e of Hea	aven Cemeter			ilver S	ring, Maryland			
ā	armit.		21. Signature of Funeral Service Licer	1500	f	THE TEACHER	s countins	Funeral	Home I	nc.			
	70 E 9 9		James St	John						ring, MD 20901			
			23a. Part 1. Anter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not en		. ,	or respiratory arre	est,	Approximate Interval Between			
ş.	Physician		Immediate Cause (Final disease or condition Onset and Death Accielant										
	/Medical		resulting in death)										
	Examiner		Sequentially list conditions.	b									
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8760	cate t	dical		_ d.									
S X	ding f		IF FEMALE:	23c. If yes, outcome of pregn	ancy				004 0-4-	of delice of			
Box	eath certific ettending p I for use as i	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fet	al death 3	Ectopic pregnancy Other (specify)			Moni	of delivery th Day Year			
o.	that the de ed by the e detached t	by Physician/Me	1 □ Yes 2 No 9 □ Unknovn	9☐ Unknown	16am 5	_ Other (specify)							
σ.	that the	유	Part II. Other significant conditions of	contributing to death but not re	sulting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use contri	bute to the cause of death?			
d S	ires tha signed d be del			-				1 ☐ Ye	s 2 % o	3 ☐ Probably 4 ☐ Unknown			
Division of Vital Records,	w require been si should b	Completed	-					24a. Was a	245 14	ere autopsy findings available			
ĕ	e law has je 2 s	m E						autops	y pr	ior to completion of cause of eath?			
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ō	Phys this ral di	-T	1 ☐ Yes 22 No 27. Manner of Death	matient 2L	ER/Outpatie	nt 3L DUA	4 Li Nursing F	lome 5 Reside					
n	Attending Physician: r death. ector: After this certific by the funeral director.	for	Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	Wor	k? Yes 2 □ No		,,				
S	deatl deatl ctor: y the	lca	3 ☐ Suicide 6 ☐ Could not b	8 One Diego of Injuny At I	nome, farm, st			28f. Location (St	reet and Numbe	r or Rural Route Number,			
<u>≤</u> .	or A efter Dire	Certification:	4 Homicide determined	building, etc. (Spec	ify)	,		City or Towr					
	spita sours neral		29a. Certifier 12 Certifying Pt	nysician: To the best of my kn	owledge, dear	th occurred at the tin	ne, date and place	and due to the ca	ause(s) and man	ner as stated.			
	HO 124 h	Medical	(Check only 2 Medical Examone)	niner: On the basis of examin and manner stated.	ation and/or ir	nvestigation, in my o	pinion, death occi	urred at the time, da	ate and place, a	nd due to the cause(s)			
	To the Hospital or Attending Physician: The within 24 hours effer death. To the Funeral Director: After this certificate hackmostely filled in by the funeral director, page	¥	29b. Signature and title of certifier	0/N.		29c. Licens	e number	2	9d. Date signed	(Month, Day, Year)			
			DEUE C	/ / MAS		1	7627	8	9-21	-06			
	15+1		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type	, Print)		- 1.1	20 M	0.601-			
			Dovd E. Cara	1, MD Coasted 1	45pm	FO By	C/733 S	50/15	1011	7180-			
	Sta Regist		31. Date filed (Month, Day, Year) SEP 2 2 2	32 Registrar's Sign	ature	all B							
		617	3ET 22 6	UUU FARRALE A	J' ASS	Service Services							

Division of Vital Records, P.O. Box 68760,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 006 Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** SEPTEMBER 23 2006 3:40PM Virginia Ward Marie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SOMERSET PRINCESS Anne MANOKIN MANOR 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min 1 ☐ M 2 😿 F Yrs. Director 216-18-2440 86 Maryland 07/08/1920 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov tre Madical Extriner must be notified at 1 Yes 2 No **Funeral Director** Princess Anne Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21853 USA 11974 Edgehill Terrace 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) none F.W. Woolworth Salesperson Pages 1 and 2 should be filed viment of Health and Mental Hygie tant: If item 27 is marked other tigury or other traumatic avent, II. Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Minnie Ingersoll Morris Page Ward ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Monticello Ave., Salisbury, MD 21801 Marian Price/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 □ Donation 5 □ Other (Specify) Allen U.M. Cemetery | 09/27/2006 | Allen, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD21853

Part 1. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one crue on each line.

MD21853

Approximate Interval Between the mode of dying, such as cardiac or respiratory arrest, on each line. M00295 Approximate Interval Between Onset and Death mediata Cause (Final disease or condition resulting in death) DELLE LALOW **Physician** MERKER CELL MONTHS CARC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed burial-transit Due to (or as a consequence of) physician by Physician/Medical as the t esn 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year or in the past 12 months2 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEMENT.A 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an GRER TENS. 2has autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes Attending Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death. Diractor: After 5 Pending investigation 1 Alatural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Thomicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEPTOMBER 25. 2006 00062916 30. Name and addr s of person completed cause of death (Item 23a) (Type, Print) SALIS BARY 11V15.0N SMITT GUTTOMMEZ,

DHMH 17 Rev 1/200

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

		1 - For State of Stat	Maryland / De <i>C</i>	partment of Hertificate of I		ental Hygie	2006	31861					
Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month September	Day 300	3. Time of Death 7:15 PM					
/Medic Examin	al	Anna Clyta Weaver 4a. Fecility Name (If not institution, give street and numb	er)	4b. City, Town, or	Location of Death	Septemen	4c. County of Dea						
LAdifiit	CI	108 Southway		Havre	de Grace		Harfo	rd .					
Funeral		5. Social Security Number 6. Sex 7. 218-46-1793 1 M 2 XF	Age (In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Pay, Ye 9/11/190	9. Bir	thplace (State or Foreign ountry) Th Carolina					
Director		Usuat Residence of Decedent	101			9/11/100	J NOT	ar carorina					
arylan show	2	10a. State 10b. County MD Harford	10c. City, Town o	r Location re de Grace	2			10d. Inside City Limits 1 ☐ Yes 2 XNo					
the M 28a-f	recto	10e. Street and Number	1100	10f. Zip Code		10g.	Citizen of What C						
th with 23a or	Funeral Director	108 Southway		210	078		U.S.A.						
er dea Itams	uner	11. Marital Status 12. Was Decede Armed Force	s?	 Was Decedent of H tf Yes, specify Cuba 	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi						
urs aft	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give Year or Date		1 ☐ Yes 2 🛛 No	Specify:		Specify: Wh:	ite					
72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usual Occup- live kind of work done of e. DO NOT use retired	ation during most of working	16t	. Kind of Business	/Industry					
within lene.	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)	e. bo nor use retired emaker)		In Home						
at yielite Z i Z i 3-0030 should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or Itams 23a or 28a-f show umatic event, in Madical Examinat must be notilised at	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name		den Sumame)						
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nd 2 silth an alth an r traur		W. Marshall Hamilton (S		4 Southway		re de Gra		21078					
partilliore, intal yiallia ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-1 show any injury or other traumatic event, the Madical Examinating the notified at once.		20a. Method of Disposition 120 Burial 2 Cremation 3 Removal from State 14 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial Gdns. 20c. Location - City or Tow											
Dartillor Dearnit, Pages Department of Important; If it any injury or o		*4 ☐ Donation 5 ☐ Other (Specify)	erdeen, N	Maryland									
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w requires to been signed should be	letec	ant Sto	(16011)			24a. Was an	24b. Were a	utoosy findings available					
VICION: The lavicion: The lavicertificate has	Completed					autopsy performed	prior to death?	completion of cause of					
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Attending For death. ector; Atter by the funera	27. Manner of Death 28a. Date of Injury 1 Matural 5 Pending 28b. Time of Injury Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No												
or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building	Injury - At home, farm, etc. (Specify)	street, factory, office	2	8f. Location (Stree City or Town, S		ural Route Number,					
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director, After this certificate he completely filled in by the funeral director, page	edical Co	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
ro the vithin 2 ro the complet	Med	29b. Signature and the of certifier	stated.	29c. License	number	29d.	Date signed (Mon	th, Day, Year)					
F-2F-0		1 Stinu T. 4	20 MI	Do	015152	2 /	0/2/06						
3		30. Name and address of person who completed cause	of death (ttem 23a) (Ty	pe, Print)	LADUA +	tumde	Grace (n021078					
Sta Registr		31. Date filed (Month Day, Year) 2006 32 eg	istrar's Signature	Carle			1						

		•	For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment of H	ealth and N Death		giena 006	31862
			Decedent's Name (First, Middle, La	st)			177		2. Date of Dea	ıth	3. Time of Death
П	Physici		Charlotte Virgin	ia Wann	ont				Sept.	28 2006	11:20pm M
7	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of Death		4c. County of De	
	- Admini		708 Shirley Drive	,			Aberdeen	1.		Harford	
	Funeral		5. Social Security Number 6. S	Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days		8. Date of Birtl (Month, Day		rthplace (State or Foreign Country)
7	Director		213-28-5605	□M 2 X □F	75	Yrs.	Monard Says	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	08/08/1	931 Mar	yland
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ecation				10d. Inside City Limits
	sho	5									1 Yes 2 □ No
	28e-i	Director	MD Harfo	<u>ld</u>	A	berdeer	10f. Zip Code			10g. Citizen of What C	Country?
	with with	ă	708 Shirley Drive	2			21001			USA	,
	ns 23	Funerai	11. Marital Status	12. Was Dec	cedent Ever in	U.S. 13.	Was Decedent of Hi	spanic Origin? (Sp	pecify Yes or No-	14. Race - Arr	
(0	r iter	Fu	1 ☐ Never Married 2 ☐ Married	Armed F 1 ☐ Yes	2 X No		If Yes, specify Cuba	n, Mexican, Puerto	o Rican, etc.)	Black, Wh	ite, etc.
03	al', o	þ	3 X Widowed 4 ☐ Divorced	If Yes, G Year or I			1 ☐ Yes 2 💢 No	Specify:		Specify: W	hite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28e-f show with the Medical Examiner must be molified at	Completed	15. Decedent's E (Specify only highest gr)		dent's Usual Occupa		kina	16b. Kind of Busines	s/Industry
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7	ygier ygier her th	Col	11th			Sec	ietary	40 44-14-1-1-1	- /film A & distable	Church	
	be fill	Be	17. Father's Name (First, Middle, Last	,						Maiden Sumame)	
2	d Mer nark natic	2	James Martz 19a. Informant's Name/Relationship	Tuna Print)		10h Mailie	an Address (Street a		Inez Dib	D r, City or Town, State,	Zin Codel
Maryland	d 2 s th an T is r traus	1	Sandra John- Daug				Everest Di			-	Zip Gode)
စ်	1 an Heal tem 2		20a. Method of Disposition	mei	20b.	Place of Dispo	sition (Name of		Date	20c. Location - City of	r Town, State
D L	ages ant of tt: If ii y or c		1 Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Speci		n State Ha		natory or other place Nem. Grdn.	· 1 .	3/06	Aberdeen,	Maruland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner mast be notified at Once.		21. Signature of Funeral Service Lice								
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D	pe eq	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Duate	(or as a conse	equence of):					
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8760,	cate be executed physician and the burial transit	dicai E		d							
9	ificati g phy as the	0					•				
Вох	n cert andin use	N/	IF FEMALE: 23b. Was decedent pregnant		utcome of prega		Ectopic pregnancy			23d. Date of d	,
ω.	deati e atte	sicia	in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{No} \)		gnant at time of		Other (specify)			Month	Day Year
P. O.	that the death certified by the attending (by Physician/M	9 🗆 Unknown								
	Se De	by	Part II. Other significant conditions	ontributing to	death but not re	esulting in the u	nderlying cause give	en in Part I.			to the cause of death?
pic	w require been si should I	te d							1 1	'es 2 □ No 3 □ I	Probably 4 Unknown
ec	law las b	Completed							24a. Was a autop	sy prior to	autopsy findings available completion of cause of
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Vita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	NO.	th (Check only o		
of	S S	2	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time o	II JU DOA	4 Nursing H		lence 6 Other (Sp now injury occurred	ecify)
no	ding h. After funer	tion	1 ☑Natural 5 ☐ Pending	(Mo	nth, Day Year)	Injury	Work	(? Yes 2 □ No	200. 20301100 11	iow injury occurred	
Division of Vital Records,	l or Attanding Ph after death. Director: After th I in by the funeral	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Plac			reet, factory, office		28f. Location (S	Street and Number or I	Rural Route Number,
<u>S</u>	after after I Direct d in by	Certification:	4 Homicide	buile	ding, etc. (Spec	cify)			City or Tow	m, State)	
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by									cause(s) and manner	
	the Hi in 24 the Fi	ledical	опе)	and ma	nner stated.	ation and/or in				date and place, and du	
	To To Com	Σ	29b. Signature and title of certifier	4			29c. License		1	29d. Date signed (Mor	
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	10		30. Name and address of person who	completed cau	use of death (Ite	em 23a) (Type,	Print)	- + 5	301600	~ MD 2	1231
	Sta	ate.	31 Date filed (Month, Day, Year)	32.	Registrar's Sign	nature	P	ee j	/ LI 17510/	C .4.1) C	71
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2006 31863 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2ªy us hotes 09494 M ocent /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 1 🔀 M 2 🗆 F 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 217-26-3360 Yrs 77 Director AUGUST 28,1929 MARYLAND Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1X Yes 2 No MARYLAND HARFORD DARLINGTON Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3212 CEDAR CHURCH ROAD 21034 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: BLACK δ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. CONSTRUCTION WELDER 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fit Department of Health and Mental Himportant: if item 27 is marked ot any injury or other traumatic ever once. Pages 1 and 2 should be nent of Health and Mental STANTON WEBSTER SERINA AKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBBIN SCOTT / DAUGHTER 575 HALL COURT, HAVRE DE GRACE, MARYLAND 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State R.A. FERRIS & CO, INC 4 ☐ Donation 5 ☐ Other (Specify) 9/27/06 WEST CHESTER, PA 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, 21. Signature of Funeral Service Licensee MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Right Lower **Physician** Tuck /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The taw requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, UNE 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 Yes 21 No or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No i Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by illed in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier - A. Kobert DUNCM 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier W. MAC Duce Oleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 11 cms 15 16a b 20b 21 22 per fh e860 10-5-06 vt State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Reg. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** (1:28 Ellen 2006 WALTERS 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner MONSTO COURD GENERAL Columbia Howard Hugertal If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 8 - 21 9. Birthplace (State or Foreign Country) R 91 N 1 19 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖫 F Months 225-14-1378 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28e-1 show PHSYLVANIA other treumatic event, the Madical Experiment ust be notified at 1 ☐ Yes 2 ENo KINGGOL Directo 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 1265 SANdy Careet Church Rond U.S.B 24586 or Items 23e Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ■ No If Yes, Give Year or Oates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. 1 Never Married 2 Married Specify: RIACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 E No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tobacco Worker Tobacco 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ruffin LIZZIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8322 Painted Rock Rdy Columbia, MD. 21045 Bety W. Elders permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9-17-06 1 Burial 2 Cremation 3 Removal from State SUNNY Level Church Cem. RINGGOLD, UA. ' 4 ☐ Donation 5 ☐ Other (Specify) 221 S. MAID 22. Name and Address of Facility 21. Signature Carriton Co Pouglass per dvr L.H. Brooks + BRO. Tames W. Danville, Va. 24541 23a. Part1./Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANOXIC ENcephalopeth **Physician** WEEK /Medical **Examiner** STRUKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be detached for use as the burial-transit WEEL DERSIS attending physician and Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 28 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🔀 No 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation Natural 1 Yes 2 No death. 2 Accident within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Learnifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D60469 MO of person who completed cause of death (Item 23a) (Type, Print) CEDAL LONG Columbia 5755 31. Date filed (Month, Day) 32 egistrar's Signature Year)

State

Registrar

OCT 0 5 2006

State of Maryland / Department of Health and Mental Hygiens, 006 1 - For State Registrar 31865 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Willma Celeste Wilhite 6:45 P M September 18, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 💢 F Yrs. 135-28-8326 Director 70 16, 1935 Dec. Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be political at Maryland Anne Arundel Edgewater 1 Yes 2X No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3808 Outrigger Drive 21037 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2XNo 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐No Specify: If Yes, Give Year or Dates: White Š 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anthony Sappington Willie Mae Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 ie Tania Vargo/daughter 470 Madison Drive Shrewsbury, Pennsylvania 17361 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H ant: If ite **XXB**urial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department Important: If eny injury or once. 9/21/2006 Annapolis, Maryland Hillcrest Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia Physician 1 day disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Cerebrovascular Accident 1 month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 4☐Pregnant at time of death 5 Other (specify) the a signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has 1 Yes 20XNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Hospital or Attending PI 24 hours after death. Funeral Director: After the 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X atural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral (29a. Certifier XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 29b. Sign ture and title of ce 29c. License number 29d. Date signed (Month, Day, Year) D 45149 September 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Bolaji Onabolu Onabajo, MD 301 Hospital Drive Glen Burnie, MD 31. Date filed (Month, Day, Year) SEP 2 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/200

			1 - For Stata Registrar	State of Ma	ryland / De		ent of H	lealth and	Mental Hy	giene	9	21066		
			Decedent's Name (First, Middle, Last)				210 07	- Journ	2. Date of De		· UUD	3. Time of Death		
	Physici		Leo Youn	o ·					Month	Da				
	/Medi Examir		4a. Facility Name (If not institution, give	<u> </u>		4b. C	ity, Town, o	r Location of Deat			. County of Dea	6 12:39 M		
			The Johns Hopki	ns Hospita	1	Ва	altimo	re City		n	one			
	Funeral		Social Security Number 6. Security Number	x 7. Age	(In yrs. last birtho		der 1 Year	If Under 24 Hrs.				thplace (State or Foreign		
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	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location						10d Inside City Limits		
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	the N	Director	Maryland Baltimor 10e. Street and Number				Zip Code			10a Cit	0g. Citizen of What Country?			
	within 72 hours after death with the Maryland ene. then "naturaf", or items 23s or 28s-1 show ta Madical Exercitive trust te rediffied at	۵	9 Stone Gate Court			101.	21208	3		-	U. S. A	*		
	death ms 2:	by Funeral		12. Was Decedent Ev	er in U.S.	13. Was De	cedent of H	ispanic Origin? (S In, Mexican, Puerl	pecify Yes or No		14. Race - American Indian,			
9	after or it	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📉 No					o Rican, etc.)					
8	raf,	b by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes	2 X No	Specify:		Specify: White				
Maryland 21215-0036	72 h	Completed	15. Decedent's Edu (Specify only highest grade		16a. De	ecedent's U	sual Occupa	ation during most of wor	rkına	16b. K	Kind of Business/Industry			
12	within hen	ם	Elementary/Secondary (0-12)	College (1-4or 5+)							II			
Ω Β	Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	5+	ET	ectri	cal E	ngineer	no /First Middle	U. S. Government Ue, Maiden Sumame)				
au(ontal	Be	Samuel Young						Kessler					
<u></u>	should od Me mark matik	ဥ	19a. Informant's Name/Relationship (Ty	ne Print)	19h M	ailing Addre	ass (Stroot	and Number or Ru			s Tour State	Zin Code)		
Σ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Menial Hygiene. Important: if Item 27 is marked other then "natural", or items 23s or 28s-f show eny finiting or other treumatic event, the Medical Ever than that Le notified at once.		Jo-Ellen G. Turner	,				Court, Ba			21208			
ē,	Itan Sta		20a. Method of Disposition		20b. Place of Di	sposition (for crematory of	Vame of		Date	20c. Lo	cation - City or	Town, State		
Ë	Page III		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Judean	Mem.	Gdns	9/1	8/2006		Olney, Maryland			
Baltimore,	mit. pertr		21. Signature of Funeral Service License	88		22. Name	and Addres	s of Facility	Momoraio	-1 CI	nanala	ls, Inc.		
m	88 5 8		Donald C.	Store	much									
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	Physician	. 9	Immediate Cause (Final disease or condition Respiratory Failure											
	/Medical		resulting in death)	l	consequence of):									
	Examiner		Sequentially list conditions.)	umonia							24 Hours		
	ad sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of).									
	icate be executed physician and s the burial-transit	хаш	that initiated events resulting in death) Last	Due to (or as a	consequence of);									
760,	be e	calE		240 10 (5) 43 4 (onsequence or).									
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×	eath certificat ettending phy I for use as th	Ž	IF FEMALE: 23b. Was decedent pregnant	3c. ff yes, outcome of	pregnancy				200		23d. Date of det	liven		
Ď.	death e ette d for	Icia	in the past 12 months? 1 □ Yes 2 □ No	1∐Live birth 2 4∏Pregnant at tir	Fetal death	3 □Ectopic 5 □ Other (Month	Day Year		
P.O. Box	that the de led by the detached t	Physician/Med	9 Unknown	9 Unknown										
S,	The law requires that the death certifica lie has been signed by the ettending ph bage 2 should be detached for use as if	by P	Part If. Other significant conditions con	tributing to death but	not resulting in th	e underlying	g cause give	en in Part I.	23e. Did to	obacco u	se contribute to	the cause of death?		
ğ	w require been si should b	ed	Esophageal Cancer						101	Yes 2	No 3□Pr	obably 4 Unknown		
မိုင်	e law r has be	Cholangitic Cancer								an	24b. Were au	itopsy findings available		
<u> </u>		Completed	•						autop perfo	rmed?	death?	compfetion of cause of 2█ No		
ita /ita	Physician: T r this certificet rral director, pa	Be (25. Was case referred to medical examiner?					26. Place of Dea						
<u></u>	Physi this c	Pospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other										cify)		
u C	Afte une	<u>ö</u>	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	'ea <i>r)</i> 28b. Time 'njur	у	28c. Injury Work		28d. Describe I	how infur	y occurred			
Division of Vital Records,	tten deat tor:	Cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Pface of fnjury	- At home, form	M street fact		∕es 2 □No	Opt Leasting //	O4-4-4	741			
<u>≤</u>		Certification:	4 Homicide determined	building, etc. (Specify)	Street, racti	ory, office		City or Tow	vn, State	a Number or Hi)	ıral Route Number.		
	To the Hospital or Al within 24 hours after or To the Funeral Direction plate in by		29a. Certifier 17 Certifying Phys	ician: To the best of r	ny knowledge, de	eath occurre	ed at the tim	e, date and place	and due to the	cause(s)	and manner as	stated		
	n 24 l n 24 l o Fu	edicai	(Check only 2 Medicat Examinone)	er: On the basis of ex and manner state	(amination and/o	investigation	on, in my op	inion, death occur	rred at the time,	date and	place, and due	to the cause(s)		
	To the within 2 To the complet		29b. Signature and title of certifier)		2	9c. License	number		29d. Dat	ate signed (Month, Day, Year)			
	10		Marland	, MP			RES	000		Sept	ember 2	0, 2006		
			30. Name and address of person who con								0160=			
			Stephanie Gaillar 31. Date filed (Month, Day, Year)					et, Balt	imore,	Md.	21287			
	Star Registra		SEP 2 2 20	32 degistrar's	Signature	back	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Yea Month **Physician** 9:30 Рм Oct. 2006 Stanlev . Arambiges Ambridge /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Oct. 1914 Director 283-12-3852 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f shov r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Baltimore Cockeysville Md. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 14 Flanders Ridge Court 21030 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc 1 Yes 2 If Yes, Give Year or Dates 1 ☐ Never Married 2 X Married 2 X No .0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bakery & Elementary/Secondary (0-12) College (1-4or 5+) Business Delicatessen Owner Department of Health and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Angela Varellan Kyriakos Arambiges ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14 Flanders Ridge Court Cockeysville, Md. 21030 Mrs. Konstantina Ambridge/Wife Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Greek Orthodox Cem. 10/11/06 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee Towson, Maryland 21204 1050 York Road blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or composhock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) 120010 **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown as been signed by 2 should be detac Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2□ No 3 ☐ Probably 4 Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury s after deameral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D 29a. Certifier 1 🖯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 31. Date filed (Month, Year) 32 Registrar's Signature State 0 2006

Registrar

State of Maryland / Department of Health and Mental Hygien 2006

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** October 4, P M 2006 4:15 Augustine James Adomanis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mitchellville Prince Georges Villa Rosa Nursing Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 □ F 87 May 26, 1919 Pennsylvania Director 163-10-7480 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23a or 28a-f show the Medical Exercines must be notified at 1XXYes 2 □ No Directo Maryland Prince Georges Bowie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3005 Belair Drive 20715 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 42-45 1 Never Married 2X Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "n. any injury or other treumatic event, Item Media 2006. Elementary/Secondary (0-12) College (1-4or 5+) Construction Superintendent 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Petronella Latvis Theodore Adomanis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Reginia M. Adomanis/ Wife 3005 Belair Drive Bowie, MD 20715 20b. Place of Disposition (Name of cometery, crematory or other place)
Maryland
Veterans Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/13/2006 Cheltenham, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Euneral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a, Part1, Enter the disease, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lu es (C) 16 /Medical Due to (or as a consequence of) Examiner AKKINGON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ cete hes been signated bage 2 should b 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy rmed? 2 No 1 Yes Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 10-05 2261 3+1 30. Name and at ress of person ocompleted cause of death (Item 23a) (Type, Print) 9500 Annapolis Road Lanham, MD 20706 Richard Feldman, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 1 0 2006

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 6 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Charles E. Alcorn, Jr. 8, 3**:**58 October 0 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caton Manor Nursing Home Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 215-14-0741 Feb. 8, 1921 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location "naturai", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits Yes 2 No Funeral Director Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2, once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3003 Ottowa Avenue 21230 United States 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Sheet Metal 17. Father's Name (First, Middle, Last)
Charles E. Alcorn, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Lowrey 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Alcorn - Nephew 401 Nancy Avenue, Linthicum, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crwonsville
Crwonsville 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) 10-11-2006 Crownsville, MD 22. Name and Address of FacilityAmbrose Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or a mplications that cause the death. D not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stage demention **Physician** monety /Medical Due to (or as a consequence of): Examiner failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: The law requires that the death certificate be executed physician ar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autopsy performed? 1∐ Yes 20 No To the Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Other: P 1 ☐ Yes 2**□** Mo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Spepte MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Shakunmalo

31. Date filed (Month, Day, Year)

9650

32. Registrar's Signature

Santiago Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#23a,25, perME, g800, 10/12/06 II Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Atober 900 200C Baby 02 Girl Allen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1th more Johns Hoplins Hospita if Under 1 Year | Il Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 TF NA Director 9-29-06 Md Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f ehow 10a. State 10b. County Y⊡Yes 2 No Director Md. NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With ь other then "natural", or itams 23a or vent, the Medical Examinar must be 5551 Force Road 21206 USA Pages 1 and 2 should be filed within 72 hours after death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Infant NA Infant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) is marked of Allen William Johnson Angela 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Health ar Important: if item 27 is eny Injury or other traugate. 5551 Force Road Angela Allen Mother , Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition h Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-9-06 Dundalk, Md Mt. Carmel Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East l adup 21202 warren 1101 E. North Avenue, Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Complications of Breech Birth Immediate Cause (Final disease or condition resulting in death) NEONATAC **Physician** DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown After this certificate hes been signed by i funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ormed? 2 X No 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner?
1. Yes 22000 Be 26. Place of Death Check only one Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death investigation 2 Accident within 24 hours efter death To the Funerel Director: , comp etely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel Certifying Physician: To the best of my knowledge death occurred at the time. Jata and place and due to the cause(s) and namer as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P.O. OCTOBER 2, 2006 RES - 000 Y 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar N

31. Date filed (Month, Day, Year)

TRIVIL DO

PILAWAY

CIRCUE

1625

32. Registrar's Signature

BAUTINDER , MARY AND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006

31871

		•	For State Registrar	State of Ma	. ,		tificate of			Reg. No			
	Dhuaisia		1. Decedent's Name (First, Middle, Las	st)					2. Date of De Month	ath Da	у	Year	3. Time of Death
	Physicia /Medic	al .	Judith Marie Arn						October			006	/,7/FM
	Examin	3	4a. Facility Name (If not institution, give	4	i 0.	. 10	4b. City, Town,	or Location of De		1	. County		ndei
_			Social Security Number 6.5	ton Medica		st birthday)	If Under 1 Yea		Irs. 8. Date of Bir			9. Birthpl	ace (State or Foreign
	Funeral Director				58	Yrs.	Months Day	s Hours M	Irs. 8. Date of Bir (Month, Da DEc. 10	y, Year)	947	Penr	nsylvania
	land	ł	10a. State 10b. County		10c. City,	Town or Lo	cation					10	d. Inside City Limits
	Mary	to	Maryland Anne Aru	nde1	Pasa	dena							1 ☐ Yes 2 XNo
	or 28s	Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of W	/hat Coun	try?
	23a c	ral	8011 Warton Ct.				21122					State	
	tems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		. 13.	Was Decedent of f Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.))-		e - America k, White, o	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	0		l□Yes 2⊠N	o Specify:			Specify.	Whi	te
۾	2 hou	ted	15. Decedent's Ed	ducation		16a. Dece	lent's Usual Occ	upation		16b. K	(ind of Bu	siness/Ind	
学	within 72 hours after death with the Maryland ene. then "neturel", or items 23a or 28a-f show the Marical Examiner must be notified at	Completed	(Specify only highest gra	College (1-4or 5-	+)	life.	OO NOT use retii		working				
To	ygiene /giene f. the	Con	1			Fina	ncial Re	*			nkin	~	
175	be fill d oth even	Be	17. Father's Name (First, Middle, Last, Charles Heckman						Name (First, Middle	, Maider	n Sumam	θ)	
-Z	2 should and Mer le marke raumatic	ဥ	19a. Informant's Name/Relationship (Type Print!		19h Mailie	ng Address (Stre		a Diamond Rural Route Numb	er City (or Town	State Zin	Code)
Na Ma	id 2 si th an 27 le r traur		William O. Arnole		1				sadena, Ma				
Arnold, Inditionse	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heelth and Menial Hygiene. Item 27 is marked other then "neturel", or items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at		20a. Method of Disposition				sition (Name of natory or other p		Date			City or To	
₹ E	Pages nent of int: If it iry or o		1 ⊠Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif				en Mem.		2006 12	G1e	n Bu:	rnie,	Maryland
Arno Baltimore,	permit. Pages Department of I Important: If Ite eny injury or o		21. Signature of Fur eral Service Licer	ns		K. 4	Name and Add irkley-R 21 Crain	ress of Facility uddick	Funeral Ho S.E., Glei	ome,	P.A	· MD	21061
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.						11110	, 110	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	one cause on each line	0.5+	atic	Pan	erecti	c Cane	ev			Onset and Death
	/Medical		resulting in death)	a. Due to (or as a	conseque	ence of):							
	Examiner	,	Sequentially list conditions,	b				<u></u>					
1	sit s	Examiner	rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	k conseque	anca of).							
Λ	tificate be executed g physician and as the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a	conseque	ence of):						_	
68760,	sician buria			d									
289	ifficate g phy as the	edical											
Вох	attending for use a	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			∃Ectopic pregnar	ncv			23d. Dat	e of delive	ory D <i>a</i> y Year
	of the deal by the att	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at t 9☐ Unknown			Other (specify)				NO	THAT	Day 1661
, P.O	res thet I	ьу Рһ	Part II. Other significant conditions	contributing to death bu	ıt not resul	ting in the u	nderlying cause	given in Part I.	23e. Did	tobacco	use cont	ribute to th	ne cause of death?
rds	w require been sig should b								_ 1_	Yes 2	2 □ No	3 🗆 Prob	ably 4 @Unknown
Division of Vital Records,	e la hes je 2	Completed											psy findings available inpletion of cause of
tal	siclan: Th certificate rector, pag	0	25. Was case referred in medical	-1				26. Place of	1 ☐ Yes Death (Check only		0	1 1 1 6 3	242110
<u> </u>	Physicl this cer al direc	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpatier	nt 2 🗆 E	R/Outpatie	nt 3 DOA	Other: 4 - Nursin	ng Home 5 ☐ Res	idence	6 □Oth	er (Specif	y)
0	ding PI h. After th funeral		27. Manner of Death 1	28a. Date of Injur (Month, Day		28b. Time o Injury	V	Vork?	28d. Describe	how inju	ury occuri	red	
sio	death. ctor: A the fu	cat	2 Accident investigation 3 Suicide 6 Could not be		uni. Al bos	no form of		☐Yes 2☐No	28f Location	(Street a	and Numb	er or Bur	il Route Number,
Divi	after of Direction by	Certification;	4 Homicide determined	28e. Place of Inju- building, etc			eer, ractory, one	æ	City or To	wn, Stat	te)	Gr Or Ture	Trodie Namour,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of miner: On the basis of and manner sta	examinati	rledge, deal on and/or in	h occurred at the vestigation, in m	time, date and p y opinion, death o	lace, and due to the occurred at the time	cause(: , date ar	s) and ma nd place,	nner as s and due to	tated. the cause(s)
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	L > F 0		Heory	J. Wi	rh	MI	D'	41365		0 d	ober	17	2006
_	0		29b. Signature and title of certifier 29b. Signature and title of certifier 30 Name and address of person who teo vige to will be a signature and title of certifier.	completed cause of de	eath (Item	23a) (Type	Print) tal	Drive	Glen L	342	mie.	, MD	21061
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 0 20	32 Hegistra	ar's Signat	ure	sells						

State of Maryland / Department of Health and Mental Hygien $lpha\,0\,0\,5$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 6, 2006 **Physician** ABUGOV 4:50 A M GITA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE JEWISH CONVALESCENT CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 12/23/1914 9. Birthplace (State or Foreign County) BELARUS 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🕡 F 91 220-94-5939 Director Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits ir then "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 Tes 2 No Director BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11909 TARRAGON ROAD - APT. J 21136 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) **TEACHER EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental marked o NAUM KHANINA (UNKNOWN) (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is any injury or other traisons. 1820 GREENBERRY ROAD - BALTIMORE, MD 21209 IGOR ABUGOV / SON 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State BALTIMORE HEBREW CEM. 10/09/2006 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2HEIMERS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of) Physician/Medical the use as 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death the o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has birector, page 2 s 2 □ No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Hospital: Other: 4 Jursing Home 5 Residence 6 Other (Specify) 2110 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral is 27. Mann Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Meen cause of death (Item 23a) (Type, Print) SN EEM

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

06-07530 Kimberly Broady

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 31873

	1- For State Certificate of Death Reg No. 1- Descriptive Name (First Middle Last) 1- Descriptive Name (First Middle Last) 1- Date of Death													
Physicia	411/	1. Decedent's Name (First, Middl	e,Last)							Date of Deat Month			3. Time of Death	
ledical Exami	ner		Broady							October 6,		31	0601 hrs	
into a		4a. Facility Name (If not institutio 3739 Dolfield Avenue	n, give street and n	umber)		b. City, T Baltim		ocation of D	eath		4c. County	of Death		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)		er 1 Year	If Under 2	4Hrs 8	. Date of 8 irt	h(MM/DD/YYY)			
Director		220-04-3118	1 M 2 XF	22	Yrs	Months	s Days	Hours	Min.	01/11/	/1984	Foreign Cou	ntry) Maryland	
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or it	Fun		1 Yes	2 X No						, ,			_	
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be (Edward Broady						Kim S	Short					
21 ould to i Men		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailing	Address	(Street a	and Number	r or Rura	Route Num	ber, City or Tow	n, State,	Zip Code)	
MD id 2 sho lith and m 27 is aumati		Cheryl Butler	/ Guardia	n	4427	Raspe	Ave	nue,	Balt	ltimore, Maryland 21206				
Te, l and Heal Titem er tra	ſ	20a Method of Disposition 1 X 8urial 2 Cremation	0 D		lace of Dispos ematory or oth			tery,	Da	Date 20c. Location - City or Town, State				
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		4 Donation 5 Other St		TOTTI State	Zion			1	0/14	0/14/2006 Landsdowne, Maryland				
alti mit Dartm porta	4	21. Signature of Funeral Service	Licensee						ie De	errick	C. Jon	es F	/H, P.A.	
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Division Hospital or Attendia 24 hours after death. Funeral Director: /	ertification:	deter	d not be	ce of Injury - At hor	me, farm, stree	et, factory,	office buil	lding, etc.	28f	Location (S or Town, S		er or Rura	al Route Number, City	
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	ĭĬ	29b. Signature and title of certifie			_	29c	License r	number			29d. Date sign	ed (Mont	h, Day, Year)	
oku		Joisha	Sea	1 NIO			O.C.M.	.E.			October 6,	2006		
1		30. Name and address of person Tasha Greenberg MD	who completed cay		,	Penn S	treet R	altimore,	MD 2	1201				
St	ate	31. Date filed (Month, Day, Year)		eg ar's Signatur		4		Samole,	, 2	.201				
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	yland		10a. State 10b. County 10c.	. City, Town or Lo	cation				10d. Inside City Limits
:	a-1 st	ctor	Maryland Baltimore	Ros	sedale				1 ☐ Yes 2 No
3	or 28	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	
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	er de Items	Funeral	11. Marital Status 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Yes 2 □ □ Never Married	in U.S. 13. V	Yas Decedent of Hi Yes, specify Cubai	spanic Origin? (Spe n, Mexican, Puerto f	Rican, etc.)	Black, Wh	
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·	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene it the state at 1 secure 23e or 28e-f show item 27 is marked other than "natural", or thems 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at		Regina Bowers, Daughter 20a. Method of Disposition	b. Place of Dispo	sition (Name of	D		Oc. Location - City of	
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	or A after Dirac in by	Certification:	4 Homicide determined 259. Flace of Injury building, etc. (S.	pecify)	cot, laddry, office		City or Town	n, State)	
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	To the Hospital or Attand within 24 hours after death To tha Funaral Diractor: . completely filled in by the f	Me	29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signed (Mo	onth, Day, Year)
1	10		12.00		D	53462		9/29/0) 6
1	(4)		30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)		- ' '		21061
				345 5)AKWOOd	Road	Suite	100 Gle	niBurnie M
		ate	31. Date filed (Month, Day, Year) OCT 1 0 2006	Signature	AP -				
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DHMH 17 Rev 1/2001

ORIGINAL

06-07536 Valerie Brady

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 2006 31875 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 6, 2006 1140 hrs **Medical Examiner** Valerie Brady 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Perry Hall **Baltimore County** 8924 Whitetail Court If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs last birthday) Days Hours Min Director 163-54-5346 02/18/1964 Country) PA 42 1 M 2 X F Usual Residence of Decedent 10d Inside City Limits an, 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No 23a or 28a-f show notified at once. Perry Hall Baltimore Maruland Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Markal Hygiene Department of Health and Markal Hygiene of the Important: If item 27 is market other than "natural", or items 23a or 28a-f sho
injury or other tranmatic event, the Modical Examiner must be notified at once. Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country' 8924 Whitetail Court 21128 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, 11. Marital Status Armed Forces White, etc. 1 Never Married 2 X Married Yes 2 X No White Widowed Divorce Yes, Give Year 1 Yes 2 X No specify: Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Deli Clerk Food Service 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Sylvia Suchocki Be Brady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8924 Whitetail Court, Perry Hall, MD 21128 Tannis C. Tracy (spouse) 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 10/11/2006 Baltimore, MD Bayview Crematory 4 Donation 5 Other Specify: 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Codeine, hydrocodone and diphenhydramine Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit Physician/Medical X UNPENDED AMENDED attending physician for use as the burial 11/28/06 TT perME. Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Month Day Year 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed ricate has been si page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy After this certificate has death? performed? 2 No Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical 26 Place of Death (Check only one) Be Hospital: 1 examiner? Other₄ DOA Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 1 V Yes 2 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural 5 Pending Fnd 10/6/2006 filled in by the Fnd 11:30 ar unknown Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 X Suicide Could not be or Town, State) 8924 Whitetail Court atonsville, MD determined (Specify) Catonsville. House Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. October 7, 2006 Mire

State Registrar

gistrar's Signature

Assistant Medical Examiner

Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD.

31. Date filed (Month, Day, Year) 2006

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2:45 PM **Physician** ELizabeth 10 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRanklin Square HIMORE If Under 24 Hrs. Dital 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 1 M 2 F **Funeral** Days Hours 213-36-3370 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits e how or then "netural", or iteme 23a or 28a-f ehor the Medical Examinar must be notified at 1 ☐ Yes 2 1 No **Funeral Director** MID 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ()SH 13. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐Yes 2 VNo specify: White 1 ☐ Yes 2 ☑ No Specify: Be Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) tallstor N/Bousekeeping other traumatic event, Mother's Name (First, Middle, Maiden Sumame) Father's Name (First, Middle, Last) 2 should ena 19a, Informant's Name/R, lationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, C. 90da) 21050 of Heelth i Pages 1 end mar Itimore, Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition 20b Date ō 1 Burial 2 ☐ Cremation 3 Bemoval from State injury or Baltimore permit. Pag Department Important: If eny injury o 4 □ Donation 5 □ Other (Specify) 106 Oaklawa 21. Signalura of Funer Service Licens Peral Chapel and Cremation Services Belair 3 Newbort Dr. Forest Hill, MD 21050 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one are used line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MEtastatic Cancer Small Cell Lung /Medical Due to (or as a consequence of) **Examiner** Pheumonia Sequentiafly fist conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed et ending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 STROKE 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed? 2.12 No 1 ☐ Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☑ Yes 2 ☒ No Certification: To 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Pis 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after dec. 1 XNaturaf 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funers! Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Chack only one) Ambient in the date and place, and due to the cause(s) and manner stated. the second 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) D45530 assilam M'D 10-09-2006 36. Name and address of person who completed cause of death (Item 23a) (Type, Print) 914 Philadephia road, MD21237 S. SIVASAILAM Jule 208, 3 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

			For State Registrar	State of Maryland	/ Department of h		-	ena 006	31877
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	G	BRY	ANT	2. Date of Death Month		3. Time of Death
	Examir Funeral Director		5. Social Security Number 6. Sex 216-28-3296 1□	DICAL CENT	ER ANN	A PO L /S If Under 24 Hrs. Hours Min.	5		. /
	e Maryland 3a-f show Illied at	ctor	Usual Residence of Decedent 10a. State 10b. County MARY LAND ANNE ARUM	0	Town or Location	NTON	/	,	10d. Inside City Limits 1 ☐ Yes 2 No
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ratinent of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show injury or other traumatic avent, the Michell Examination until the multiplian at a.e	Funeral Directo		OWER COUL	10f. Zip Code R 7 13. Was Decedent of Fif Yes, specify Cub	2/1/3 Hispanic Origin? (S	5	g. Citizen of What Cou	Andrean Indian,
9000	72 hours after dea natural, or Itema	ρχ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	1 □ Yes 2 No	Specify:		Specify: B	LACK
21215-0036	e filed within 72 lal Hygiene. lother then "net vent, the Micela	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of wor	rking	66. Kind of Business/Ir BALTO CITY AU	BUC SCHOLS
Maryland	should be filed ind Mental Hygi marked other umatic avent, ii	To Be C	17. Father's Name (First, Middle, Last) GEORGE	GRI		ETH	ne (First, Middle, Mi	aiden Sumame) STEU	VART
-	es 1 and 2 sh of Health and f Item 27 Is m r other traum		19a. Informant's Name/Relationship (Typ KIRK BRYANT 20a. Method of Disposition	(SON)	19b. Mailing Address (Street 2 2 2 5 5 5 Dee of Disposition (Name of letery, crematory or other pla	ENHOWE	CT, ODE	ENTOWN, State, 21, ENTOWN MD 0c. Location - City or T	.21113
Baltimore	permit. Pages Department of Important: If It any Injury or o		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	ME1		Ry 10-1	12-06 X	BALTIHOR. FUNERA	E, MD. AL HOME
	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	cations that caused the death.	Do not enter the mode of dyill	ng, such as cardiac	or respiratory arres	3AL70, HL St.	Approximate Interval Between Onset and Death
	/Medical Examiner	_	resulting in death) Sequentially list conditions, if any, leading to immediate				J		
Ĩ	cate be executed physicien and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequer					
09289	rtificate be ng physicie as the bur	Icai	L d.						
P.O. Box	es that the death certific igned by the attending p be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal do 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 Ectopic pregnance	у		23d. Date of deliv Month	very Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions cont	tributing to death but not resulti	ng in the underlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
al Records,	iician: The law r certificate has be rector, page 2 sh	Completed		semento	3.		24a. Was an autopsy perform 1 Yes 2	eti? prior to co	lopsy findings available ompletion of cause of
ion of Vital	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompistely filled in by the funeral director, page 2 should be detached for use as it	atlon: To Be	25. Was case referred to medical examiner? 1		8b. Time of 28c. Injury Wor	ner: 4 🗌 Nursing H	ome 5 Resider 28d Describe hov	nce 6 Other (Speci	ify)
Division	tal or Atters after desal Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Rur State)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Examin	ician: To the best of my knowle ler: On the basis of examination and manner stated.	n and/or investigation, in my o	opinion, death occu	rred at the time, dat	te and place, and due t	to the cause(s)
	or viet	~	29b. Signature and title of certifier	Defenta	29c. Licens	2143	()	d. Date signed (Month,	Day, Year)
	3		39. Name and address of person who co	holeted cause of death (Item 2	r Defens	E Alar	tway A	NNAPOLIJ 1	MO21401
	Sta Registr		OCT 1 0 200	32. Registrar's Signatur	South				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Lawrence Scott Brownlee Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ October 7, 2006 1745 hrs Medical Examiner Brownlee Scott Lawrence 4b. City, Town, or Location of Death 4c County of Death 4a. Facility Name (if not institution, give street and number) Baltimore 3600 Pulaski Highway 8. Date of 8irth(MM/DD/YYYY) 9. 8irthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 5. Social Security Number 6. Sex **Funeral** Foreign Months Davs Hours Director 213-72-0999 November 11,1960 Country) Maryland 45 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County Yes 2 X No 28a-f show Edgemere Maryland Baltimore with the Maryland Director 10a Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 28 notified a 21219 USA 9324 Sea Point Road Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack Funeral 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces' 1 XNever Married 2 Married 2 X No Yes ō 1 Yes 2 X No specify: Specify: White after 3 Widowed 4 Divorced If Yes, Give Year 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of 8usiness/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 and Mental Hygiene MD 21215-0036 Construction 11 years Carpenter 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked Charles Alan Brownlee Yvonne C. Yeater Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9324 Sea Point Road, Edgemere, Maryland Pages 1 and 2 shunent of Health and ant: If item 27 is Mother Yvonne Hilling 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery or other tra Baltimore, October crematory or other place) Burial 2 X Cremation 3 Removal from State Bayview Crematory Baltimore City, MD. permit Pages
Department of
Important: 1 10, 2006 Other Specify Donation 5 ^{22, Name and Address of Facility} Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. Sunature of Juneral Service Licen Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** 8etween Onset and failure. List only one cause on each line. /Medical Death Cocaine and narcotic intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical X UNPENDED ing physician as the burial -AMENDED item#23a,27,28a-f,perME,g861,11/9/06 TT Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown ₽ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24a Was an 24b. Were autopsy findings available certificate has been prior to completion of cause of autopsy performed? death? ✓ Yes ✓ Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be Hospital: 1 Other₄ Nursing Home 5 Residence 6 Other. Scene OOA Inpatient ER/Outpatient 3 After this 1 🗸 Yes 28c. Injury at Work 28d Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Yea 27 Manner of Death Certification: Natural 5 Pending death. Fnd 10/7/2006 FNd 5:35 pm unknown 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 3600 Pulaski Hwy. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be or Town, State) 3
Baltimore, MD determined (Specify) found outside a motel Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated 10 29d. Date signed (Month. Day Year) 29c License number 29b. Signature and title October 8, 2006 O.C.M.E une 30. Name and address of person who completed cause of death (Item 23a) Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 David Fowler M.D. 32 Registrar's Signature 31 Date filed (Month, Day, Year State 2006 Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate o	f Death	, ,	1. No 200	C 2107			
Physici	an/	Oecedent's Name (First, Middle,Last)			2. Date of Death	200	Time w Death			
Medical Exami	ner	Tyrone Jabar Boyd		·	Month September		0047 hrs			
		Facility Name (if not institution, give street and number) Johns Hopkins-Bayview		4b. City, Town, or Location of Deat Baltimore	h	4c. County of Death				
Funeral			In yrs. last birthday)		s 8 Oate of Birth	(MM/OD/YYYY) 9. Birl	holace (State or			
Funeral Director				Months Days Hours Mi	n.	Foreig	n			
		unknown 1 M 2 F Usual Residence of Decedent		3.	July 15	1978 NE	W'York			
any	ŀ		Oc. City, Town or Loca	tion			10d. Inside City Limits			
* .	_	NY Kings	Brooklyn	ı			1 X Yes 2 No			
Maryland 28a-f show d at once.	sct	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cour	ntry?			
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s afte ral",	þ	Widowed 4 Oivorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete)		Yes 2X No specify: nt's Usual Occupation (Give kind of	work done	Specify: 16b. Kind of Business/I	Black			
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336 thin 7: than than edical	Completed	12		sing Assistant		Medicine				
15-0036 filed within 72 hours after Hygene. do other than "natural", c	ပ္ပြ	17. Father's Name (First, Middle, Last)		18.Mother's Nam	Mother's Name (First, Middle, Maiden Surname)					
21215-0036 and be filed within 7 Mental Hygiene. marked other than	a	Jerome Boyd		Helen :	Laverpool					
ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	유	19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number or			1			
Malth alth and 2		Mrs. Helen Boyd, Mother 20a Method of Oisposition	3549	Nostrand Avenue sition (Name of cemetery,	Apt. 27	A, Brooklyn	NY 11229			
Baltimore, permit Pages I an Department of Hes Important: If ite		1 Surial 2 Cremation 3 Removal from State								
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Baltimore permit Pages I Department of I Important: If	1	21 ture of une Arylice Licensee MC		Name and Address of Facility Jo 19 Liberty Avenue			07			
Physician		23a. Part I. E. t. the discusse, or complications that caused th					Approximate Interval			
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a, Multiple Gunshot	Wounds				Between Onset and Death			
Examiner		or condition resulting in death) Due to (or as a consequence)								
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876 tiffcat ng phr as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome 1 Live birth		etal death 3 Ectopic pregr	nancy	23d. Date of delivery Month)ay Year			
Box 687: c death certifi. the attending cell for use as t	icia	4 Pregnant at tir	no of doath	ther (Specify)						
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b.O. E that the d	by F	Part II. Other significant conditions contributing to death be	out not resulting in the	underlying cause given in Part I.		2 No 3 Prob				
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the start death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Completed				. 24a. Was a		topsy findings available			
SOFC law re has be 2 sho	l du				autops perform	y prior to d	ompletion of cause of			
tal Rection: The certificate ector, page	ပ္ပ	22.0		00 B) (B) (B) (B)	1 ✓ Yes 2	No 1 ✓ Ye	s 2 No			
ital sician: s certi	Be	25. Was case referred to medical examiner?	2 ✓ ER/Outpatien	26.Place of Death (Check t 3 DOA Other Nurs		Residence 6 Other				
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ivision of the after de Directo din by t	fica	2 Accident Investigation Sep 26, 2006 3 Suicide 6 Could not be 28e. Place of Injur		et, factory, office building, etc.		reet and Number or Ru	ral Route Number, City			
Divospital of hours af numeral Divospital of hours af numeral Divospital Divo	Certification:	4 Homicide determined (Specify) Multi	-Family Apt.		or Town, Sta 7587 Hives L	ate) ane apt G, Dunda	alk, MD			
D E Hospital 24 hours E Funeral etely filled		29a. Certifier 1 Certifying Physician: To the best of my k								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 Medical Examiner: On the basis of examinand manner stated.	nation and/or investiga		at the time, date a					
	Σ	29b. Signature and title of certifier		29c. License number		29d. Date signed (Moi				
		Milla		O.C.M.E.		September 27, 2	UUb			
		30. Name and address of person who completed cause of dea Ana Rubio MD. Assistant Medical Examin		Street, Baltimore, MD 2120						
	toto	31. Date filed (Month, Day, Year) 32. Registrar's		Jacob, Dallimore, MD 2120	, ,					
S Regis	tate trar	OCT 1 0 2006	was St. to	only						

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 31880

Lamont Donte Brown	State of Maryland	/ Department of Health and Mental F Certificate of Death	¹ ygiene 2006 31881
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	Gertinoate of Beatin	Reg. No. 2. Date of Death 3. Time of Death
Medical Examiner	Lamon & Donte Bro	OWN	Month Day Year September 29, 2006 1607 hrs
	4a. Facility Name (if not institution, give street and number Sinai Hospital) 4b. City, Town, or Location of Dea Baltimore	th 4c. County of Death
Funeral		ge (In yrs. last birthday)	rs. 8, Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	213-17-1979 1 M 2 F	Q Yrs. Months Days Hours Mi	5201 13 1987 Foreign Country) Md
è	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	10d Inside City Limits
d d	AA A SOLITO		1 Yes 2 No
the Maryland a or 28a-f sh tifted at once	10e. Street and Number	Baltimore 10f. Zip Code	10g. Citizen of What Country?
the M a or 2 affed Dire	3344 Virginia Ave	21215	USA
72 hours after death with the Maryland natural", or items 23a or 28a-f show any al Examiner must be notified at once.	11. Marital Status 12. Was Deceden		Specify Yes or No- 14. Race - American Indian, Black,
er deat	1 Yes 2	No 1 Yes 2 No specify:	Specify Blank
urs afte	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade con	mpleted) 16a Decedent's Usual Occupation (Give kind of	work done 16b. Kind of Business/Industry
5-0036 ed within 72 hours after dygiene other than "natural", or the Medical Examiner m. Completed by Ft.	Elementary/Secondary (0-12) College (1-4 or	5+) during most of working life. DO NOT use re	itired)
15-0036 filed within 7 LHygiene ed other than 1, the Medical e Comple	10+1	UNEMPIONED	N/A
215-(be filed or the other orth. The other orth. The other orth. The other orth. The other orth. The other orth. The other orth. The other orth.	17. Father's Name (First, Middle, Last)	18 Mother's Nan	ne (First, Middle, Maiden Surname)
AD 2121! 2 should be fil h and Mental F 27 is marked matic event, I	19a. Informant's Name/Relationship (Type, Print		Rural Route Numbia, City or Town, State, Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after nent of Health and Mental Hygiene trans If frem 27 is marked other than "natural", or other transmaric event, the Medical Examiner. To Be Completed by I	Sylvia Wallace Mo	ther 3918 Wabash Ave	
or Heal	20a Method of Disposition 1 Burial 2 Cremation 3 Removal from S	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Baltimore, MD 21215-00 remit Pages I and 2 should be filed wit Department of Health and Mental Hygien important: If item 27 is marked other njury or other trammatic event, the Mi To Be Com	4 Donation 5 Other Specify:	Grunmound Cemetery 10	19/06 Baltimore Md national Harris Funeral Home
Baltimore permit Pages I Department of Important: If injury or other	21 Supraure of Funeral S Mice Licensee		
Physician		d the death. Do not enter the mode of dying, such as cardiac	
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunsh	ot Wounds	Between Onset and Death
Xammer	or condition resulting in death) Due to (or as a cons	sequence of):	
- a	Sequentially list conditions, if any, leading to immediate Due to (or as a cons	sequence of):	
ted Insit	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a cons	sequence of):	
	events resulting in death) Last Due to (or as a cons		
be ex brician urial	UNPENDED AMENDED		
6876C certificate nding phys se as the b	23b. Was decedent pregnant in the	ome of pregnancy 2 Fetal death 3 Ectopic preg	23d. Date of delivery nancy Month Day Year
ox 6876 ant certificat attending phy or use as the	past 12 months?	at time of death 5 Other (Specify)	
2.O. Box 6876 that the death certificat red by the attending phy detached for use as the by Physician/M	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to dea	th but not resulting in the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?
- v 50 a	Tarkii. Other significant conditions	the but not resulting in the underlying cause given in ranti.	1 Yes 2 ✓ No 3 Probably 4 Unknown
Records, The law require ficate has been signage 2 should b			24a Was an 24b Were autopsy findings available
e law te has l			autopsy performed? performed? 1 V Yes 2 No 1 Ves 2 No
of Vital Records, ig Physician: The law require ther this certificate has been sineral director, page 2 should I. To Be Completed	25. Was case referred to medical	26.Place of Death (Chec	
Vita hysicis this ce I direc	TV Tes Z INU		sing Home 5 Residence 6 Other
of Vi ding Physi After this funeral dir	27. Manner of Death 1 Natural Pending Sep 29, 200	28d. Describe how injury occurred Subject shot	
Division ratendir rs after death. The Division and Directors A led in by the furtification	Pending Accident Sep 29, 200 Rep 29, 200 2	28f. Location (Street and Number or Rural Route Number, City	
Division o spiral or Attending rours after death. meral Director: Aft filled in by the func Certification:	Suicide 6 Could not be determined (Specify) Lo	or Town, State) Park Heights / Quantico Ave., Baltimore, Md.	
Division To the Hospiral or Attendive within 24 hours after death. To the Funeral Director: A completely filled in by the funeral Certification	29a Certifier	ny knowledge, death occurred at the time, date and place, a	
To the Ho within 24 To the Fu completed	and manner stated		
Ž	29b Signature and title of ertifier	29c. License number O.C.M.E.	September 30, 2006
	30. Name and address of person who completed cause of		Coptember 30, 2000
2	Mary G/Ripple MD. Deputy Chief Med	, ,	MD 21201
State Registrar	31. Date filed (Month, Day, Year) 2006 Registr	ar's Signature	
DHMH 17 Rev 1/2001	Jan State Control	ÖRIGINAL	

ونون		For State Registrar Amend Item 2 Decedent's Name (First, Middle, Last)		OGI	lineale	ים וט	Cairi	2. 0	Date of Death		Year	3. Time of	Death
icia dica		George S Biener							10	à	2006	5.	M
nine	er	4a. Facility Name (If not institution, give s	1.5	100	4b. City, T	own, or Lo	ocation of	Death			nty of Death	0	
		5. Social Security Number 6. Sex	are HOSP 7. Age (In yrs.	last birthday)	If Under 1		If Under 24	4 Hrs. 8. D	ate of Birth		9. Birtho	lace (State o	r Foreign
al or		215 28 3313 ¹ X	M 2□F 74	Yrs.	Months	Days	Hours	Min. C	Date of Birth Mopth, Day, LODER 3.	Y°1931	Balti	more, Ma	ryland
		Usual Residence of Decedent										21.1-11.01	
	_	10a. State 10b. County		y, Town or Loc							1	0d. Inside Ci 1 ☐ Yes	
	9cto	Maryland Baltimore	Bar	timore G		2.4.			14	Citizen	of Milhot Cour		
	吉	10e. Street and Number 8800 Walther Blvd. Ap	+ 2/.1O		10f. Zip (USA	of What Cour	itty:	
	Funeral Directo		2. Was Decedent Ever in U	.S. 13. V			anic Origi	n? (Specify		-	Race - Americ	an Indian,	
	표	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give					n? (Specify Puerto Ricar	n, etc.)	E	Black, White,	etc.	
1	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:1953–1	.956 1	Yes 2	ĽXNo	Specify:			Spe	city: Whit	te	
1	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	ent's Usual	Occupation during	on ring most o	of working	1	16b. Kind of	f Business/In	dustry	
1	apr.	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work OO NOT use		•	, ,		Doltin	oseo Coa	& Elect	maria Co
ı		17 5-15-15 North Middle (1-1)	4	CIVIL	Engine		O. Mashari	- Nome /Fir	st, Middle, N			& FIECE	ric (
	Be	17. Father's Name (First, Middle, Last)					e. womer Rosanna		st, ivildule, iv	alderi Suri	iaine)		
ı	၉	Valentine M Biemer 19a. Informant's Name/Relationship (Type	ne Print)	19h Mailin	a Addross /				uta Numbar	City or Toy	wn, State, Zip	Code)	
1		Dorothy E Biener (Wife			-						Land 212		
1	- 1	20a. Method of Disposition		Place of Dispos cemetery, crem				Date			on - City or To		
l		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		dens of			ctobe	r 6 200	6	Baltim	ore, Mary	vland	
l		21. Someture of Funeral Service License					- 1	ame Inc					
		MONTHON (4)	ach						re, Mar	uland '	21226		
igned by the attending physicien and important: if ite be detached for use as the burial-transit or or or or or or or or or or or or or		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecuency of the to (or as a consecuency of	uence of):	psis	Clos	stridi	um Diff	icile C	ditis		Onset and I	Jealii
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	l death 3 🗌	Ectopic pre Other (spe						Date of delive Month	•	Year
ı	<u>۾</u>	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	nderlying ca	use given	in Part I.			acco use c		he cause of co	death? Unknown
	Completed								24a. Was ar autops	V	b. Were auto prior to co death?	opsy findings impletion of c	available ause of
ı	ខ្ញ								1 Yes 2		1 Yes	2 No	
	Be	25. Was case referred to medical examiner?	ospital:			Other			eck only on				
	2	1 ☐ Yes 2 🔼 No '' 27. Manner of Death	1 x Inpatient 2	ER/Outpatient		~	4 Nuls		5 Reside		Other (Special	fy)	
١	힐	1 X Natural 5 ☐ Pending	(Month, Day Year)	Injury	M	Bc. Injury a Work? 1 □ Ye	 s 2∐N		5030150 110	iv injury ou	Jan 33		
l	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre				28f. I	Location (Sti City or Town		ımber or Rur	al Route Num	iber,
		(Check only 2 Medical Examir	ician: To the best of my knows: On the basis of examination and manner stated.										;)
- 1	dlcal	one)										Oau Vans	
	Medical	29b. Signature and title of Certifier	1		29c.	License r	number		2	ed. Date sig	gned (Month,	Day, Year)	
	Ψ.		123					OAC					
	Ψ.		mpleted cause of death (Iter	m 23a) (Type, I				000				À 123'	

State of Maryland / Department of Health and Mental Hygiene 0 0 6 31882 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 7:56 am FRANK E. 2006 BRYAN Oct /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of manyland medical Center Balhnore 6. Sex 1 M DM 2 □ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 212-58-4968 53 Yrs. Director Feb 1, Maryland Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits itama 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2√ No **Funeral Director** MD Baltimore N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 446 Burbank Court permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: If item 27 is marked other than "natural", or itama 23a eny injury or other treumatic event, the Medical Examinar security. 21227 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Driver Freight 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Edward Bryant II Betty Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella A. Bryant/Wife 446 Burbank Ct. Baltimore MD 21227 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other pla.
Zion Cemetery Mt∵ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-13-2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdown 21. Signature of Funeral Service Licensee 2719 Hammonds Ferry Rd. Lansdowne MD 21227 obers 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 'sagulo Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 MOWNES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certiticate be executed ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 □Unknown mondu Be Completed After this certificate has been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? death? 1 ☐ Yes Yes 2□ No 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ses 2 No 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Avatural
2 Accident s after decrea After 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Description Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person after completed cause of death (Item 23a) (Type, Print) 200 SONTH CARENE 32. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 1 0 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar		State of Ma	aryland	l / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of H te of L	lealth a D <i>eath</i>	and Me		giener Reg. No.	2006	31883	3	
	Dhunini			e (First, Middle, Last)		-					2. Date of De Month	ath Day	Year	3. Time of Death		
	Physici /Medio		Jean		Ε.]	Bascia					ctober	7,	2006	9:20 P ^M		
1	Examin	er		fnot institution, give dora Road	street and number)				y, Town, or nthic	Location o	t Death			County of Deat ne Arud			
	Funeral		5. Social Security N		x 7. Ag	e (In yrs. la:	st birthday)	If Und	er 1 Year	If Under 2	24 Hrs.	B. Date of Bir	th.	9 Rint	hplace (State or Foreigr untry)	7	
	Director		210-20-7	328 10]M 2🗓F	79	Yrs.	Month	Days	Hours	Min.	(Month, Da Aug • 2	6,192	27	PA.		
	and w		Usual Residence of 10a, State	Decedent 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits	_	
	Maryl f sho	tor	MD	Anne Arun	de1	Lint	hicum								1 □ Yes 2 😿 No		
	r 28a	Director	10e. Street and Nur						ip Code				10g. Citiz	en of What Co	untry?		
	th with		6239 Med	lora Road				21	090				U.S	U.S.A.			
36	y within 72 hours after death with the Maryland liene. r then "natural", or itema 23a or 28a-f show the Madical Examinar must be rediffed at	by Funeral	11. Marital Status 1 Never Marri 3 Widowed	ed Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2X1! If Yes, Give Year or Dates:		'			ispanic Orig in, Mexican Specify:	gin? (Spec I, Puerto R	ify Yes or No ican, etc.)		4. Race - Ame Black, White Specify: Wh	e, etc.		
00-	2 hour			15. Decedent's Edu	cation		16a. Dece	dent's Us	ual Occupa	ation			16b. Kir	nd of Business/	Industry	_	
Maryland 21215-0036	within 73 ene. then "n	Completed	(Special Special ify only highest grad indary (0-12)	e completed) College (1-4or 5	5+)	(Give life. I			during most ()	t of workin	9	Ot	vn Home				
d 2	Hyg H, Hyg	0	17. Father's Name	(First, Middle, Last)			Home	marce	_	18. Mothe	r's Name	(First, Middle				_	
ılan	o	To B	Claude Ac	kleyBisse	11					Josep	ephine Ross						
lary	s m		19a. Informant's Na	ame/Relationship (T)	rpe, Print)		19b. Mailir	ng Addre	ss (Street a	and Numbe	r or Rural	Route Numb	er, City or	Town, State, 2	Zip Code)		
	1 and 2 Health Iem 27 I		Mrs. Lisa 20a. Method of Dis	Lane			MD 210 cation - City or										
nor	000		1 🗆 Burial 2	Cremation 3 ☐F Other (Specify)			ice of Dispo metery, crer esapea			0ct 9 2006	,						
Baltimore,	글 문원을 .			her Selvice Licens		Hoi	20			ss of Facility		-		ensvill eral Ho	ome, P.A.	-	
8	perm Depa Impo		1 4	Jui-			1				SW C	Elen Bu	ırnie	, MD 21	.061		
	Physician		shock, or hea fmmediate Cause	he disease, or comp rt failure. List only o (Final	ne cause on each li	the death.		er the m	ode of dyin	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death		
į.	/Medical Examiner		disease or condition resulting in death)		Due to (or as	1									10946		
L,	3	er	Sequentially fist co	nditions,	Dire to (or as	а полвация	ince of):										
	cuted	Examiner	cause. Enter Under Cause (Disease or that initiated events	3	X												
60,	ficate be executed g physicien and as the burial-transit	ai Ex	resulting in death)	Last	Due to (or as	a conseque	ance of):										
68760,	ificate g phys as the	edicai			d												
O. Box	The law requires that the death certifite has been signed by the attending tage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 25 9 Unknown	months? ⊒No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal o	death 3	Ectopic Other (pregnancy specify)				2	23d. Date of del Month	ivery Day Year		
rds, P	quires that n signed b uld be deta	þ	Part fl. Other signif	ficant conditions co	ntributing to death b	ut not result	ting in the u	nderlying	cause give	en in Part I.			obacco u		the cause of death?	1	
of Vital Records,	The law requir ate has been si page 2 should	Completed					·						psy prmed?	prior to death?	itopsy findings available	3	
ital		0	25. Was case refer	red to medical						26. Place	of Death	1 ☐ Yes (Check only	2 0 M 6	1 ☐ Yes	2[[]]		
<u>></u>	Physician: r this certific ral director.	To B	examiner?	No.		ent 2 🗆 E	R/Outpatier	nt 3 🗆 1	Oth	er: 4 □ Nu	rsing Hom	e 5 Hesi	dence 6	6 □Other (Spe	cify)		
	ding After fune	tion:	27. Mann of Deat 1 D Natural 2 ☐ Accident	h 5 Pending investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	f M	28c. Injun Worl	yat k? Yes 2 ⊡!		8d. Describe	how infun	y occurred			
Division	ial or Attending s efter death. al Director: After ed in by the fune	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inj building, et	ury - At hom c. (Specify)	ne, farm, str	reet, facto	ory, office		2	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
1)	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one)		sician: To the best ner: On the basis o and manner st	f examination											
_	To the within 2 To the comple	Me	29b. Signature and	title of certifier	11-	1	_	2	9c. Licens	e number	51/		6	e signed (Mont	h, Day, Year)		
	.0		10	WILL -	soval	3			117	009	14		10/	109/01			
	10		30. Name and addi	9016alu	ompleted cause of a	Seath (Item :	23a) (Type, 14010	Print)	Park	ED	rive	Gle	n/k	Burnie	oud. 2100	6/	
	Sta Registi		31. Date fifed (Mon	th, Day, Year)	6 82 Registr	ar's Signatu	ire do	rete	i			1				•	

			For State Registrar		State o	f Maryla			ent of H		nd Me	ental Hyg	giene Reg. No.	とせせり	3	1884	
			Decedent's Name (First, Mide	dle, Last)			2					2. Date of Dea			1	me of Death	
	Physici /Medic		Leon				5	60h			(Octop	51.	2 2001		1. 28PM	
	Examin	er	4a. Facility Name (If not instituti	on, give si		11000	1 nti	4b. C	ty, Town, or	Location of		P	4c.	NA County of Dea	th		
	Funeral		5. Social Security Number	6. Sex	KINE	7. Age (In yr:	s. last birthd		der 1 Year	If Under 24	4 Hrs.	8. Date of Birt	h	9. Birl	hplace (S	itate or Foreign	
	Director		215-18-0329	1∕₹	M 2□F	84	Yrs	. Montl	ns Days	Hours	Min.	(Month, Da)	v, Year) 0–19:		untry) [N	Id.	
	p >		Usual Residence of Decedent 10a. State 10b. Count	hu		100.0	ity, Town o	r Location							10d Inc	ide City Limits	
	lanyla	5	Md.	NA		100.0		Ltimor	~0							Yes 2 No	
	the A	rect	10e. Street and Number	IVA			Da.		Zip Code				10g. Cit	izen of What Co		7	
	3a or	Funeral Director	2834 Ashland	Avenı	ue				2120	5				USA			
	death	ner	11. Marital Status			edent Ever in	U.S.	I3. Was De	cedent of Hi		n? (Spec	cify Yes or No-		14. Race - Ame Black, Whit		an,	
36	hours after death with the Maryland tural; or Items 23s or 28s-f show at Examinar must be notified at		1 Never Married 2 Ma		1. Yes If Yes, Gir	2 □ No ve			2√ □ No	Specify:		,			lack		
21215-0036	d within 72 hours after death with the Marylan jiene. I then "natural", or items 23a or 28a-f show the Medical Examinat mast be notified at	ed by	3 Widowed 4 Divorce		Year or D	ates:	16a De	acedent's U	sual Occupa	ation			16b K	ind of Business			
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212	e filed within in Hygiene. other then "r	E O	12th grade		College (1-40(5+)	I	abore	er				Bet	thlehem	Stee	el	
pu	O 10 77 -	Be	17. Father's Name (First, Middle	, Last)								(First, Middle,	<i>Maid</i> en	Sumame)			
yla		ဥ	John			В	ean				nelia		-				
Maryland	d 2 sho th and 7 is mu treum		19a. Informant's Name/Relation Ella Bean		wife			•	•			Baltin		or Town, State,	21205	:	
	s 1 and 2 should f Health and Mer Item 27 is marke other treumatic		20a. Method of Disposition	v	ATTE_	20b.	Place of D	sposition (Name of	- 1		ate		ocation - City or	_		
OE .	Pages nent of int: if it iry or o		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		emoval from	State	cemetery, King N		or other place Park		LO-7-	-06	Rai	ndallst	own,	Md.	
Baltimore,	in the second	l	21. Signature of Funeral Service	e License	18					s of Facility	1	March F					
<u> </u>	Pen fm p		1 Safellula				6	1101	E. N	orth A	lveni	ue, Bal	time	ore, Md	. 21	.202	
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complic st only on	e cause on e	caused the de each line.	ath. Do not	enter the n	node of dying	g, such as ca	ardiac or	r respiratory ar	rest,		Interv	oximate al Between t and De <i>a</i> th	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a.		cardi		-nfa	ction						ONR	1	
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		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b, b,		(or as a con	equence of):	reny	ase	926					7-4	_v 5	
	cuted nd ransit	Examine	Cause (Disease or injury that initiated events	1 .													
Ö,	cate be executed physicien and the burial-transit		resulting in death) Last		Due to	(or as a conse	equence of):										
8760,	The law requires that the death certificate be executed to be to be the steed by the attending physicien and bage 2 should be detached for use as the burial-transit	dlcal		d.													
9 x	eath certific attending p	/Me	IF FEMALE:	23	3c. If yes, ou	tcome of preg	nancy							23d. Date of de	live rv		
Вох	death a atter d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		1 ☐ Live t 4 ☐ Pregr	ointh 2 ☐ Fe nant at time of	tal death	3 ☐Ectopie 5 ☐ Other	pregnancy (specify)					Month	Day	Year	
O.	t the de by the tached	hys	9 ☐ Unknown		9□ Unkn	own									_		
S, D	igned be de	by P	Part II. Other significant condi	0		eath but not re	sulting in th	e underlyin	g cause give	en in Part I.				use contribute to		./	
ord	w requir been si should	ted	H/2 heimers	176h	nenti	a, Hy	pert	usto	ν			101	/es 2	∐No 3∐P	robably	4 DUnknown	
Sec.	e law hesb je 2 sl	Completed									_	24a. Was		24b. Were a prior to death?	utopsy fin completic	dings available in of cause of	
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Ξ		o Be	examiner?	_	ospital:	Inpatient 2	XER/Outpa	atient 3	DOA Othe	20		(Check only o		6 □Other (Spe	ocifu)		
J Of	g Phys ter this neral di	\vdash	27. Manner of Death	Seminarii .	28a. Date		28b. Tim	e of	28c. Injun Work			8d. Describe I					
sior	Attending r death. ector: After by the fune	catic		stigation				М		Yes 2 □ N	0						
Division of	al or Attending PI s after death. al Director: After ti ad in by the funera	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined	28e. Place build	of Injury - At ing, etc. <i>(Spe</i>	home, farm cify)	, street, fac	tory, office		2	8f. Location (S City or To		nd Number or R e)	ural Rout	e Number,	
	Hospital 24 hours a Funeral I tely filled		29a. Certifier 1 Certify	ina Phys	ician: To the	a best of my k	nowledge. d	eath occur	red at the tim	ne date and	place a	and due to the	cause(s) and manner a	s stated.		
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical one)	al Examin	er: On the b	pasis of examination of stated.	nation and/o	r investigat	ion, in my or	pinion, death	occurre	ed at the time,	date and	d place, and du	e to the ca	ause(s)	
	To the vithin 2 To the complet	ž	29b. Signature and title of certif	ier	1				29c. License	number			29d. Da	te signed (Mon	th, Day, Y	(ear)	
)			Mah 3.	fly	her m	0.			0250	199			00	3/2006			
5	415		30. Name and address of person	in = 6 acr	mplet cau	se of death (It	əm 23a) (Ty		7 .14'	.0.45 55	1		(0.000			
ĭ	Sta	to	31. Date filed (Month, Day, Yea	(Q.5 ar)	32.4	egistrar's Sig	01te	27	Dalti	MOLE	- 1/	you Ala	NCI	21287			
	Registr		OCT 1	0 200	400	2000.2	1	March	0								

State of Maryland / Department of Health and Mental Hygien 206 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month NIN **Physician** 2006 2154 7 October /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE THE JOHNS HOPKINS HOSPITAL Under 1 Year If Under 24 Hrs. onths Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 11XM 2∏F 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Yrs. 235-36-6778 80 1926 West Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Madical Exeminar must be notified at 1 ☐ Yes 2X No Completed by Funeral Director Elkins Randolph 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Easy Street 26241 USA death 12. Was Decedent Ever in U.S. Aqued Forces? 1 ⚠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Lumber Salesman Lumber Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental ant: If Item 27 Is marked o Alvin Paul Burr, Sr. ဂ္ Bernice Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet M. Burr/Wife 103 Easy Street Elkins, WV 26241 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ö 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ortant: If Metro Crematory, Inc. 10/9/06 4 □Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Departition of the support of the su 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 Edward A. Gregorchik 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final SEPSIS 1 DAY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner IYEAR CANCER GASTRIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physicien and s the burial-transit The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending physic IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the at id be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cete has page 2 s perform certificete 2 No 2 No 1 Yes 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 Garonzik-Wang Jacqueli ne october 7 2006 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Wolfe Street Baltimore Maryland 21287 Icqueline (Saronak-Wana 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#2,15, 29a, perFH, MD, 281,11/15/06 TT

For Amend #9,16b Per FH &23d Per Phy C861 11/13/06 Jn

Reg. No. 10 6 31886 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10/05/2006 3. Time of Death **Physician** 10:35 PM Carrie Bell Brooks 10 06 2006 /Medical 4a. Facility Name (If not institution, give street and number)
Suburban Hospital 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Staror Foreign Country) Months Days Hours Min. 1 ☐ M 2 🗶 F Yrs. 12-09-1913 92 499-34-3801 Carlisle, AL Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10a. State 10b. County DC ¹X Yes 2 □ No Washington Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20011 USA 5631 3rd Street NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No ff Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry St. Louis Public Elementary/Secondary (0-12) College (1-4or 5+) Public School School 1 Educator 4 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Nichols Lucy Amelia Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Clarice Anita Byrd/Daughter 5631 3rd Street NW, Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removat from State 10-13-2006 4 □ Donation 5 □ Other (Specify) Calvary Cemetery St. Louis, MO 22. Name and Address of Facility Marshall's Funeral Home 21. Signatuce of Fuperal Service Licensee · Marshag 4217 9th St, NW, Wash. DC 20011 23a. Pairl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia Due to (or as a consequence of): Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Peripheral Vascular Disease Due to (or as a consequence of): Physician/Medical Cerebrovascular Accident IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 **∑**Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29b. Signature and title of certifier

State Registrar SAIMA

31. Date filed (Month, Day, Year) OCT 1 0 2006

Funeral

Director

or Items 23a or 28a-f ahow

other than

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if Item 27 is marked other tt any injury or other traumatic event, IIIs once.

Physician /Medical

Examiner

ettending physician and

After this certificate has been signed by the tuneral director, page 2 should be detached

death.

Director:

completely filled in within 24 hours a To the Funeral C

the

Division of Vital Records, P.O. Box 68760

filed within 72 hours after

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

JA, MD

32 Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 0 0 6 3 | 887 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year LEON COPELAND 11:50AM OCT 04 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURECARE - HOMEWOOD N/A BALTIMORE CITY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1**∑**M 2□F 74 228-36-0382 Yrs Director 11/30/1932 VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location il Hygiene. other than "naturel", or Iteme 23e or 28e-f ehow vent, the Medical Examiner must be notified at 10d. Inside City Limits BALTIMORE CITY N/AMD 1 XYes 2 No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21216 2912 GARRISON BLVD., APT. B-2 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after fX Yes 2 ☐ No if Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: BLACK ģ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION BUS DRIVER 8TH permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Important: If item 27 is marked other any liquy or other traumatic event 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be VIRGINIA JOHNSON ARTHUR WILSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 2912 GARRISON BLVD, APT. B-2, BALTIMORE, 19a. Informant's Name/Relationship (Type, Print) LINDA JOHNSON / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
MD VETERANS CEM.
GARRISON FOREST 20a. Method of Disposition Date 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/11/06 OWINGS MILLS, MD Juneral Service Licensee 21. Signature 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AV, BALTIMORE, Hack Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner S_ quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ng physician and as the burial-transit certificate be executed Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ Sign P 2 No 3 Probably 4 ☐Unknown certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan 1⊡ Yes 2☐No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 027569 e of death (Item 23a) (Type, Print) an 31. Date filed (Month, D Year) 2006 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 006 31888 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1:50 pM WILLIAM DORSEY CHAMBERS 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Biltimore City B. Himure Dinai Hospital of N/A 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F 77 Director 218-22-9212 12/29/1928 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ith and Mental Hygiene. 27 is marked other then "natural", or Iteme 23a or 28a-1 ehow traumatic event, the Medical Examinar must be notified at Y Yes 2 No BALTIMORE CITY Director N/A10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 4401 KATHLAND AVENUE 21207 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ty Yes 2 No If Yes Give US 1 ☐ Never Married 2 ☐ Married 21215-0036 Specify: BLACK 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify: ARMY 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) UNITED STATES Elementary/Secondary (0-12) College (1-4or 5+) MAIL HANDLER POSTAL SERVICE 12TH 18 Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be ould be Mental ELIZABETH CHAMBERS WILLIAM DORSEY ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 st Department of Heelth and Importent: if Item 27 Is n any injury or other traun 4401 KATHLAND AVE., BALTIMORE, MD 21207 SHIRLEY E. CHAMBERS / WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State METERANS CEM. 10/13/06 MD OWINGS MILLS, MD Donation 5 Other (Specify) CARRISON FOREST
22 Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature Funeral Service Licenses 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Inter the dispase, or complications that caused the death too not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Onset and Death diate Cause (Final Itherosckiotic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o s a consequence of) Examine ettending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the e Ö 9 Unknown 9 Unknow ۵. been signed be should be deta Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 ☐ Yes 2 ☐ No Prostate 1 ☐ Yes Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 2 €R/Outpatient 3 DOA မ this: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the Fune completely fi Medical (Check only P. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0056388 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Simi Hospital of Baltimure 31. Date filed (Mos 32 Registrar's Signature 2006 State Registrar

Knavn 95

			For State Registrar	State of Ma		epartment of F Sertificate of			ien 2 0 0 6	31889			
	Physici	an	Decedent's Name (First, Middle, Lass STELLA ELIZA)		TM A N			2. Date of Deat Month	h Day Yeer	3. Time of Death			
1	/Medic Examin	al	4a. Facility Name (If not institution, give		THAM	4b. City, Town, o	OCT.	05 2006 4c. County of Dea	4:40P				
1	Exami	iei	FUTURECARE-O	BALTI	MORE								
	Funeral Director		5. Social Security Number 6. S 218-14-1400		e (In yrs. last birthd 91 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 07/18/	Year) 9. Bin Co	thplace (State or Foreign buntry) CAROLINA			
	שַ		Usual Residence of Decedent	1717 14.									
	Maryta f show	ō	MD 10b. County N/A		10c. City, Town o	IMORE CI	тү			10d. Inside City Limits 1√2 Yes 2 ☐ No			
	or 28a-	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?			
	s 23a		3307 FAIRVIE		Ever in U.S.	2121		oity Voc or No-	USA 14. Race - Ame	arican Indian			
920	s 1 and 2 should be filed within 72 hours after death with the Maryland Fleetin and Mental Hygiene. Item 27 is marked other than "natural", or itsms 23a or 28a-1 show other traumatic svent, the Medical Examinar must be notified at	by Funeral	11. Marital Slatus 1 □ Never Married 2 □ Married 3 ☒Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If If Yes, Give Year or Dates:	No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Rican, etc.)	Black, Whit	e, etc.			
15-0	n 72 h	letec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(G	ecedent's Usual Occup ive kind of work done te DO NOT use retired	during most of workii	ng	16b. Kind of Business				
21215-0036	yene.	Completed	Elementary/Secondary (0-12) 8TH	College (1-4or 5		SPITALITY		~~	LORD BAL' HOTEL	TIMORE			
	2 should be filed within and Mental Hygiene. is marked other than sumatic svent, the Mis	Be	17. Father's Name (First, Middle, Last) ARTHUR CARTE				18. Mother's Name						
Maryland	should nd Men marke matic	2	19a, Informant's Name/Relationship (19b. M	lailing Address (Street		BONNE		Zip Code) 21215			
	and 2:		ANTONICA INGRA	1/GRANDDA			Action to the second se		, BALTIMO	ORE, MD			
nore	Pages 1 nent of He int: if iter ury or oth		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □		cemetery,	isposition (Name of crematory or other place PARK	10/1		20c. Location - City or WINDSOR I				
Baltimore,	permit. Pages 1 and Department of Heelth Importent: If Item 27 any injury or other to once.		4 □ Donation 5 □ Other (Specifical Signature of The gral Service Licer		C_ KING M	22. Name and Addre	ss of Facility HO	WELL F	UNERAL HO	OME 21207			
	⊈ 0 ≥ € 0		23a. Pal Saterithe disease, or com	plications that caused	the deem. Do not	4600 LIB	ERTY HEI	GHTS A	VE, BALT	MORE, MD			
	Physician		23a. Pan Enter the disease, or complications that caused the dock. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or art failure. List only one cause on each line. Immediate rause (Final disease condition a. CERERROVASCULAR ALCIBENT										
1	/Medical Examiner		resulting in death) Due to (or as a consequence of):										
	MERM	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of).	0			92				
	ecuted and I-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a consequence of):	,							
68760,	licate be executed physicien and s the burial-transit	edicai E		d									
	ing phi		IF FEMALE:										
P.O. Box	The law requires that the death certiticate be executed atte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		23d. Date of de Month	livery Day Year			
	w requires that the de been signed by the a should be detached t	δ	Part II. Dther significant conditions of	ontributing to death b	ul nol resulting in th	ne underlying cause giv	ren in Part I.	23e. Did tot	pacco use contribute to es 2 □No 3 □ P	o the cause of death?			
of Vital Records,	The law requirate has been page 2 should	Completed						24a. Was a autops perform	y prior to death?	ulopsy findings available completion of cause of 2 No			
Vita	Physician: The this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 Yes 2 P No	Hospital:		Ot	26. Place of Death		e) ence 6 □Other (Spe				
o of	ng Phys ter this neral di	on: To	27. Manner of Death 1 Tradatural 5 Pending	28a. Date of Inju		e of 28c. Injur			ow injury occurred	iciny)			
Division	ttsndir death. stor: Al	icatic	2 Accident Investigation 3 Suicide 6 Could not b				Yes 2 □No	28f Location (St	reet and Number or R	ural Route Number			
Di	tel or A s atter ai Direction by	Certification:	4 Homicide determined	building, et	c. (Specify)	, street, factory, office		City or Town	, State)	and House Hallbox,			
	To the Hospitel or Attending Physician: The within 24 hours atter death. To the Funeral Director: After this certilicate his completely filled in by the funeral director, page	Medical			f examination and/o	leath occurred at the tie or investigation, in my o							
	To th within To th comp	Me	29b. Signature and title of certifier	100		29c. Licens		1	9d. Date signed (Mon				
			1/0/0				122		petober 10	2006			
	H		30. Name and address of person who LEONARD RICHARDSON				IKESVILLE	MD 7.13	208				
	Sta		LEUNAR RICHARDSON 31. Date filed (Month, Day, Year) OCT 1 0 20	Registr	ar's Signature	beile							
	Regist	ar	001 T 0 50	Jan John	0 00								

DHMH 17 Rev 1/2001

		For State Registrar	State of Maryla	and / Dep	artme		alth and I	Mental Hy	Reg. No.	006	31891
Physicia /Medica Examine	al -	4a. Facility Name (If not institution, give	SPVT (Tohen		y, Town, or L	ocation of Death	2. Date of De. Month	- H	Year 2006 County of Deat	
Funeral Director		5. Social Security Number 6. Sex 1 C	are Center 7. Age (In y. 1 M 2 M F 90	rs. last birthday Yrs.			If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da June 2	h	Co	polace (State or Foreign unitry) sachusetts
a-fehow	ctor	Usual Residence of Decedent 10a. State 10b. County MA Bristol		City, Town or L							10d. Inside City Limits 1 X Yes 2 ☐ No
death with the Maryland ms 23s or 28s-f show	Funeral Director	10e. Street and Number 26 Harding Street			0	2720			U.S	en of What Co	
urs after al', or ite	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:				**	panic Origin? (S Mexican, Puert Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
within 72 hours atter iene. than "netural", or ite tre Meolical Exercitie	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2	entary/Secondary (0-12) College (1-4or 5+)				on ring most of wor	rking	Assessors Office City of Fall River		
should be filed within and Mental Hygiene. I marked other than "umatic event, the Me	To Be C	17. Father's Name (First, Middle, Last)							ne (First, Middle, Maiden Sumame) yca j		
od 2 stranger tranger		19a. Informant's Name/Relationship (Ty Judith Goodwin (Daughter)	17921	l Arc	hwood	Way., C	oral Route Number Olney, M	D 208	332	
Part Brit	20a. Method of Disposition 1 \(\tilde{\mathbb{Z}}\) Burial 2 \(\tilde{\mathbb{C}}\) Cremation 3 \(\tilde{\mathbb{R}}\) Removal from State 4 \(\tilde{\mathbb{D}}\) Donation 5 \(\tilde{\mathbb{O}}\) Other (Specify) St. Patrick Cemetery 10/14/06 Fall River,										
permit. Departr Import. any inj.		21. Signature of Furreral Service Licens	Petton	n i	Hath 1813	and Address away 1 Robes	of Facility Funeral son St.,	Service Fall R	iver,	MA 02	720
hysician /Medical Examiner		23a. Part1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a cons	sequence of):		ode or dying.	. 5	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
nte be nysicie ne bur	dicai Examiner										
rite death certifically the ettending phiched for use as the	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknowh	Vas decedent pregnant I the past 12 months? ☐ Yes 2 No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								
5 5	P S									cco use contribute to the cause of death?	
The law te has b	Completed			24a. Was auto perfo 1 Yes		24b. Were a prior to death?	utopsy findings available completion of cause of				
	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 ☐ ER/Outpatie	ent 3 🗆	Othe	- 1	ath (Check only Home 5□ Resi		S∏Other (Spe	ecify)
of ethe	⊢	27. Manner of Death Second Part Second								y occurred	
To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the the	i Certification:	3 Suicide 6 Could not be determined	building, etc. (Sp	ecify)			a date and live	City or To	wn, State))	ural Route Number,
To the Hospital or within 24 hours affe To the Funerel Dir completely filled in	edicai		sician: To the best of my iner: On the basis of exam and manner stated.		investigati	оп, іп ту ор	inion, death occ		date and	place, and du	e to the cause(s)
To t To t	Σ	29b. Signature and title of certified				29c. License	number 05942	2 3		e signed (Mon	th, Day, Year)
6		30. Name and address of person who c		,				, Maryla		ne- 7	2008
Stat Registra		Dr. Feinberg, M.D. 31. Date filed (Month, Day, Year) OGT 1 0 2000	Registrar's S		side)	Galli	craburg	, maryia	-14		

Please Type or Print in Black Indelible Ink

Geranmus Carpi		Sta 1-For State Amend 24a. De	te of Maryland	/ Depa /07 <i>Ce</i> /	artmei	nt of te of	Health Death	and	Menta	al Hy		2 No. 2	nn	6 :	3189
Physicia Medical Exami	ın/	Gentaries Damer Carput								2. Date of Death Month October 5, 2006 Reg. No. 2 0 0 0 1 0 7 3. Time of Death 2203 hrs					
		4a. Facility Name (if not institution, Sinai Hospital)		4k	City, Town		ocation of	Death	October	4c Cour	ity of Deat	h	
Funeral Director		5. Social Security Number		ge (In yrs. I		iay)	If Under 1		If Under	24Hrs.		irth(MM/DD/YY	Forei		
		Usual Residence of Decedent	1X M 2 F		46	Yrs.					02/22	/1960	C	ountry)	PA
Maryland 28a-f show any d at once.	۲	10a. State 10b. County MD Balti	more	,	Town or rkvi		1								de City Limits es 2 No
death with the Maryland or items 23a or 28a-f she	Director	10e. Street and Number 1716 Yakona Road					10f. Zip Code 21234					10g. Citizen of What Country? USA			
ath with t tems 23a	- 1	11. Marital Status 1 Never Married 2 Mari		?	.S		Decedent o				cify Yes or N tican, etc.)		ace - Ame hite, etc.	rican India	n, Black,
s after dec ral", or i	by Fu	3 Widowed 4 Divor	ced If Yes, Give Year or Dates:	X No			es 2 X					Specia		nite	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f she raite event, the Medical Examiner must be notified at once	ompleted	15. Decedent's Education (Specific Elementary/Secondary (0-12)	College (1-4 or		du	iring mos	Usual Occ tof working tory	g life. D	OO NOT us	se retire		16b Kind of Med	ica1	ringustry	
21215-0036 uld be filed within 7 Mental Hygiene marked other than	ပ၂	12 17. Father's Name (First, Middle, L						- 1				Maiden Surna	me)		
2121 nould be f in Mental is marked tic event,	To Be	Germanus S 19a. Informant's Name/Relationshi	p (Type, Print)					Street a		er or Ru		imber, City or T			
Z d Z July		Lois Carpin /				Dispositi	on (Name o			t • 30	, .	20c. Location	_		
Baltimore, permit Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremation 4 Donation 5 Other Spe 21. Signature of Funeral Service Li	cify:	A11	toona	a Cr	emato		of Escility	1/11	$\frac{1}{2006}$	Altoo			
	-	23a. Part I Enter the disease, or co		d the death	Do not	150	1 Eas	t F	ort A	Aven	ye, Ba	al Home	e, M	212	30 imate Interval
Physician /Medical 5xaminer	1	failure. List only one cause of Immediate Cause (Final disease	n each line. a. Alcohol and	fenta	nyl i				ucii as cai	diac or	respiratory a	Test, SHOCK, OF	neart		en Onset and Death
		or condition resulting in death) Sequentially list conditions,	Due to (or as a cons												
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	Due to (or as a cons c. Due to (or as a cons												
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be be	/Medical	IF FEMALE: 23b. Was decedent pregnant in the	AMENDED ite						7				of delive		Vees
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/M	past 12 months? 1 Yes 2 No 9 Unkn	4 Pregnant a	t time of de	2 eath 5	_	l death er (S <i>pecify)</i>	3 [_	Ectopic p	pregnan	су	Monti	1	Day	Year
ords, P.O. Bo: v requires that the deat s been signed by the at	by Ph	Part II. Other significant condition		th but not r	esulting i	in the un	derlying ca	use giv	ven in Part	: I.		tobacco use co			
ords, F v requires s been sign should be	Completed										24a. Was	san j24	b. Were a	utopsy find	lings available
Recc		25. Was case referred to medical	1				26.0	Place o	of Death (C	`hack or	1 Yes	ormed? 2 No	death? 1 ✓ Y	'es	2 No
Division of Vital Records, ral or Attending Physician: The law require rs after death al Director: After this certificate has been siled in by the funeral director, page 2 should b	To Be	examiner? 1 ✓ Yes 2 No		ent 2		patient	3 DOA	0	ther ₄	Nursing	Home 5	Residence		er: Scene	7.11
ion o trending death tor: After	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1 Accident Investigation Production Investigation Production Investigation Production Investigation Production Investigation Production Investigation Production Investigation Production Investigation Production Investigation Production Investigation Production Investigation Production Investigation Production Investigation Production Investigation Production Investigation Production Investigation Production Investigation													
To the little of							factory, off	fice bui	ilding, etc.		28f. Location Ba ltimo i	(Street and Nu State) Sina Ce, MD	mberorR i hosj	ural Route pital	Number, City
29a Certifier (Check only one) 29m Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) a men one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) a men one) 29b. Signature and title of certifier 29b.								use(s) and man	ner as sta	rted.)				
F N N O	Me	29b. Signature and title of certifier	and manner stated Leef Uck	·	_			cense	number			29d Date s			/ear)
8		30. Name and address of person w	vho completed cause of	death (Iten		111 [enn Stre	-			21201	1	, _ 220		
	tate	Tasha Greenberg MD. 31. Date filed (Month, Day, Year) CT 1 0 20	Assistant Medic			corte		D	ailiiiUf	e, IVID					

State of Maryland / Department of Health and Mental Hygien 206 31893 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 2006 4:30 p Helen G. Chakedis /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 8altimore Towson 538 Piccadilly Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day Year) | Min. | June 17, 1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 2√F Yrs. Massachusetts 88 Director 084-10-5470 Usual Residence of Decedent 10c. City, Town or Location 10d. fnside City Limits 10a. State 10b. Count d Hygiene, other than "natural", or Itams 23s or 28s-f ehow vent, the Medical Exercites must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Towson Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21204 538 Piccadilly Road filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: δ White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 is marked ott jury or other traumatic even Vasiliki Fillios Christos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5329 Woodlot Road Columbia, Maryland 21044 James Chakedis / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 10/10/06 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road Man Ruck Towson Funeral Home, Inc. Towson. Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) CATCLUOMA 1190 Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infilted cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physicien: The law requires that the death certificate be executed physiclen and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an to perten 11 on autopsy performed/ 2 🗆 No 1□ Yes 2 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No Certification: To 27. Manner of Dean 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftar Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Rd #202 Cockaysilk MD 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) bourence 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State	of Marylar	nd / Depa <i>Cer</i>	artment of H tificate of I	lealth and M D <i>eath</i>	lental Hygi	ene2006	31894		
			Decedent's Name (First, Middle,	Last)					2. Date of Death		3. Time of Death		
٠	Physicia /Medic		Lois J. Cohen						10	04 200	6 2:00 a M		
1	Examin	er	4a. Facility Name (If not institution,		ımber)	:	4b. City, Town, or	Location of Death		4c. County of D			
	Funeral		Suburban Hospit 5. Social Security Number	al S. Sex	7. Age (In yrs.	last birthday)	Bethesda If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9 1	Birthplace (State or Foreign Country)		
ı	Director		171-32-4347	1□M 2፟፟፟∭F	64	Yrs.	Months Days	Hours Min.	12-7-19	941 Pe	nnsylvania		
	land bw	}	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits		
	a-1 eh	tor	MD Montgo	mery	N.	Bethe	sda				1 ☐ Yes 2 ☑ No		
	or 28	Director	10e. Street and Number 10f. Zip Code 20852							g. Citizen of What USA	Country?		
	eath v	Funerai	11. Marital Status		cedent Ever in U	I.S. 13. V		ispanic Origin? (Spe	ecify Yes or No-		merican Indian,		
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. The show Tar 1s marked other than "natural; or iteme 23a or 28a-1 show other traumatic event, the Medical Examinar mast be notified at	þ	1 Never Married 2 Marrie 3 Widowed 4 XDivorced	Armed F	orces? 2√∑ No ive		f Yes, specify Cuba 1 ☐ Yes 2⁄☐xNo	Specify:	Rican, etc.)	Black, W Specify: W			
2	72 ho natur dical	eted	15. Decedent's (Specify only highest	grade completed) (Give kind of work done during most of working						6b. Kind of Busine	. Kind of Business/Industry		
21215-0036	within 72 ene. than "nat he Medica	Completed	Elementary/Secondary (0-12)	College 5-1	(1-4or 5+)	Law	DO NOT use retired Ye r	1)		Self Employed			
	other i	Be Co								(First, Middle, Maiden Surname)			
<u>Xa</u>	should be nd Mental marked o	7	William Jaffee Sarah Unterberger										
Maryland	d 2 sh th and th sm traum traum		19a. Informant's Name/Relationshi Dale B. Cohen/da			1	•	and Number or Rura			N.Y. 10003		
	s 1 and f Health item 27 other tr		20a. Method of Disposition		20b. I		sition (Name of natory or other place			20c. Location - City			
Ē	Pages ment of I ant: If its ury or o		1 ABurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe					ance 10-6	5-06	Clarksbur	g,MD		
Baltimore,	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Li	censee	MO1358		. Name and Address		nation Si	ilver ₃ Sgr	ing MD st Ave.20910		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
1	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			ary Fibro	sis			1		
	Examiner				o (or as a consec	quanca or).							
7	D #	iner	Sequentially list conditions, if any, leading to infine flatucause. Enter Underlying Cause (Disease or injury	b. Cua to	o (or as a consec	quanca of):							
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9	artifica ing ph	0	IF FEMALE:		a 1930, 133						W		
.O. Box	The law requires that the death certific ste hes been signed by the attending fa page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Tyes 2 No 9 Unknown	1 I ive high 2 Fetal death 3 Fetanic pregnancy							23d. Date of delivery Month Day Year		
Ω.	es that I igned by be deta	by Ph	Part II. Other significant condition	s contributing to	outing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of de			
ğ	w require been sig should b								1 ☐ Ye	s 2□No 3□	Probably 4 Unknown		
Division of Vital Records,	The law rele hes be page 2 sh	Completed							24a. Was ar autopsy perform 1 Yes 2	v i prior	autopsy findings available to completion of cause of 1? res 2 No		
Zi ta	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		3	oth	26. Place of Deat					
ō	Phys this al di	٦. ٦	1 ☐ Yes 2 No 27. Manner of Death	28a. Dat	e of Injury	28b. Time o	IL SLI DON	4 Nuising no	eme 5 ☐ Reside 28d. Describe ho	nce 6 Other (5 w injury occurred	Specify)		
ö	ath. or: After or: After	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	ition	nth, Day Year)	Injury		Yes 2 □ No					
DIVIO	or At after of Direct in by	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Plas	ce of Injury - At h ding, etc. (Spec	nome, farm, sti ify)	reet, factory, office	28f. Location (Street and Number or Rural Rou City or Town, State)			r Rural Route Number,		
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	ledical (29a. Certifier 1 Certifying (Check only one)	xaminar: On the	ne best of my kn basis of examin inner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	me, date and place, ppinion, death occur	and due to the ca red at the time, da	use(s) and manne ate and place, and	r as stated. due to the cause(s)		
	To the within To the comp	ž	29b. Signature and title of centrier				29c. Licens		25	9d. Date signed (M	onth, Day, Year)		
	/		· Hall			- 00 : ==		61302		10/4/06			
	15		30. Name and address of berson w					.MD20814		l			
	Sta Registi		31. Date filed (Month, Day, Year)	1 32	Registrar's Sign	ature	bechesua	J.1120017					
			4417		Y								

Cohen, Lois 10/4/00 0200 A.M.

			For State Registrar	State of Marylan		artment of F			en 2 0 0	6 31895
5	Physicia		1. Decedent's Name (First, Middle, Last) Edgar Samuel Cooke	е				2. Date of Death Month October		3. Time of Death 2006 7:40 A.M
	/Medio Examin		4a. Facility Name (If not institution, give s	treet and number)		Phoenix	r Location of Death		4c. County of	
	Funeral		4304 Green Glade 1 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		nore County 9. Birthplace (State or Foreign Country)
190	Director		227-16-7657 Usual Residence of Decedent	IM 2□F 85	Yrs.	Months Days	Hours Will.	May 4, 1		Spray, N.C.
	nyland how		10a. State 10b. County	10c Cit	y, Town or Lo	ocation				10d. Inside City Limits
	the Ma 28a-f s	Director	Maryland Baltimo:		onix_	10f. Zip Code		10	g. Citizen of W	1 ☐ Yes 2 X No
	h with		4304 Green Glade	Road		21131			Jnited S	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importanci if Item 27 is marked other than "natural", or Items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show important: Item Medical Examination in the inclified at once.	by Funeral		12. Was Decedent Ever in U Armed Forces? 120 yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hilf Yes, specify Cub. 1 ☐ Yes 2XXNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black	- American Indian, , White, etc. White
5	"natur	eted	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occup	pation during most of world)	king 1	6b. Kind of Bus	iness/Industry
2121	d within giene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) N/A	1	1 Worker			astern S	Stainless Steel
and	I be file ntal Hyg ed othe: event,	Be	17. Father's Name (First, Middle, Last) Dewey Edgar Cooke				18. Mother's Nan Radar S	ne (First, Middle, M ue Wood	laiden Sumame	J
aryl	should and Me a mark umatic	To	19a. Informant's Name/Relationship (Type	pe, Print)		-	and Number or Ru	ral Route Number,		
e, ⊠	1 and 2 Health em 27 I		Mrs. Sharon Ratlic			Green G. osition (Name of	lade Road			and, 21131 Dity or Town, State
mor	Pages nent of int: If It		1 Burial 24 Cremation 3 R 4 Donation 5 Other (Specify)	0	cemetery, crei	matory or other pla	apel Oct.			Hill, Maryland
Baltimore, Maryland 21215-0036	permit. Departm Importa any inju		21. Signature of Funeral Service License	em	P 2	2. Name and Address eaceful 7 325 York	Alternati Road, Ti	ves Fune monium Ma	cal&Cremaryland	nation Ctr. P.A 21093
10,			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the deat ne cause on each line.	h. Do not ent	ter the mode of dyn	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
Ž.	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	Card	10 pul	mma	zyms	su ffic	iency
	Examiner	Sequentially list conditions, if any, leading to immediate b. Qenevalized debility Due to (or as a consequence of):								- 1
/	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq		ing h	eart	fail	ure	
8760,	icate be executed physicien and s the burial-transit	al Ex	resulting in death) Last	Due to (or as a cohseq		FILM	, ((a +1	~		
9	ntificate ng phys as the	Aedicai	(F. F. S. W. S.					9-1		
.O. Box	the death certificate be executed y the attending physicien and ched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnant 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of continuous 9 □ Unknown	al death 3[Ectopic pregnanc Other (specify)	у		23d. Date Mon	e of delivery th Day Year
σ.	w requires that the de been signed by the a should be detached t	β	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	inderlying cause gr	ven in Part I.			bute to the cause of death? 3 Probably 4 Unknown
l Reco	The law ate hes t page 2 s	Completed				24a. Was ar autops perform 1 Yes 2	v pr	Vere autopsy findings available rior to completion of cause of eath?		
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	1-0-0	Ott	ner.	th (Check only on		
Division of Vital Records	ing After une	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Inju	4 Nursing r	ome 5 Feside 28d. Describe ho		
Divis	or At or At or At or At or At or At	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st	reet, factory, office		28f. Location (St. City or Town		er or Rural Route Number,
	To the Hospital within 24 hours a To the Funerel I completely filled	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.						
	To the within 2 To the comple	Med	29b. Signature and talk of pertified			29c. Licen	se number	29	9d. Date signed	(Month, Day, Year)
	0 4 1		1 / While	Jomp	- 00:3	DIG	1318	ì	0 9	06
	2		30. Name and address of person who co	ompleted cause of eath (Ite	Rd (Type,	Phoe	nix	My	2113	1
	Sta Registi		31. Date filed (Month, Day, Year) OCT 1 0 2006	32 Registrar's Sign	ature	2000				

		•	1- State of Maryland / Department of Health and Certificate of Death	Mental Hygiene	2000 31030
1	Physicia	an	Decedent's Name (First, Middle, Last)	2. Date of Death	
	/Medic	al	LANUE CUARK TIL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	OCHIBLR 5	2006 303 9 M
	Examin	er	Maryland General Hospital Bultimore C		N A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Min. Months Days Hours Min.	(Month, Day, Year)	9. Birthplace (State or Foreign Country)
	Director		LIS- 14-0232 16d M 2 L F 35 Yrs. World Says Hours Usual Residence of Decedent	10.18.1970) MD
	nyland show		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ■ Yes 2 □ No
	he Ma	Director	MD NA BALTIMORE 10e. Street and Number 10f. Zip Code	100 Cit	izen of What Country?
	3a or 3		3910 DOLFIELD AVENUE 21215	109. 01.	USA
	eme 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Surprise Forces) 14. Was Decedent of Hispanic Origin? (Surprise Forces)	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	be filed within 72 hours after death with the Maryland stal Hygiane. ed other then "naturel", or Iteme 23a or 28a-f ehow event, the Medical Exeminar must be neutified at	by Fu	t [2] Never Married 2 Married 1 Yes 2 [2] No I Yes 3 Widowed 4 Divorced Year or Dates:		Specify: BLACK
21215-0036	72 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo		ind of Business/Industry
121	within ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		AREHOUSE
d 2	Hygi ther int,	Be Co	A W Odisc	me (First, Middle, Maiden	
ylan	should be filed and Mental Hygi marked other umatic event, I	To B	LANUE CLARK JR MARY	CARTER	
Maryland	S S S S S S S S S S S S S S S S S S S		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R 39b DOLFIED AVE 39b DOLFIED AVE	70 110	or Town, State, Zip Code)
	ges 1 and 3 is of Health If Item 27 or other tra		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery cremetory or other place)	Date 20c. Lo	ocation - City or Town, State
Baltimore,	Pages ment of i ant: If its ury or o		1 Burial 2 (@Cremation 3 Hemoval from State 4 Donation 5 Other (Specify) GREENMOUNT 10.	2.06 BAL	TIMORE, MO
Balt	permit. Page Department of important: If any Injury or once.		21. Signiture of Funaral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE 51.51 BOLTO, NOTI: Pik	FUNERAL SE	EVICE
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	**************************************	Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	K	Onset and Death
1	/Medical Examiner		resulting in death) Due to (or as a consequence of):		
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		
	cuted	Examiner	that initiated events c.		
60,	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):		
68760	e de	edicai	d		
Вох	leath certifica ettending ph for use as t	Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery Month Day Year
	he dea the etched	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify)		marur say
, P.O	res that the de igned by the e be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco i	use contribute to the cause of death?
ords	w require been sig should b	ted t		1 ☐ Yes 2	
Vital Records,	e law i has be	Completed by		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
tal		a	25. Was case referred to medical 26. Place of De	1 ☐ Yes 2 ☐ ✔6 eath (Check only one)	
of Vi	Physician: this certific ral director,	To B	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 Residence	6 □Other (Specify)
	ding P. After t	:lon:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation M M 1 ☐ Yes 2 ☐ No	28d. Describe how injur	ry occurred
Division	t or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street are City or Town, State	nd Number or Rural Route Number,
Ö	ital or urs afte ral Dtr lled in	Cert			
	To the Hospital or Attending Physipin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifler (Check only one) 29a. Certifler (Check only one) Check only one) Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the best of my knowledge, death occurred at the time, date and place of the best of the be	e, and due to the cause(s urred at the time, date and) and manner as stated. d place, and due to the cause(s)
	To the comple	Me		29d. Da	e signed (Month, Day, Year)
,			1 2000	(0)	92/99
2	/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	nonoral	HOSDHEIL
	Sta		31. Date filed (Month, Day, Year) OCT 1 () 2006 32. Registrar's Signarlare		
	Registi	rar	00110		

			For State Registrar	State of Mary		artment of H rtificate of L		lental Hygie Reg.	ZUUb	31897
			Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death
	Physici /Medic		Par	nela Schwei	ickhard	t Coakle	V	October 8	Day Yeer 8. 2006	3:00 A ^M
	Examin		4a. Facility Name (If not institution, give				Location of Death		4c. County of Deat	h
			1795 Rochester	Street		Crofto			Anne Aru	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In I ☐ M 2 🖾 F	yrs. last birthday Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		hplace (State or Foreign buntry)
н	Director		577-60-8251 Usual Residence of Decedent		61 115.			NOV 5, 19	944 Lou	isiana
	land ow		10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	Many Feb	to	Maryland Anne Ar	undel		Crofton				1 ☐ Yes 2X No
	or 28s	Director	10e. Street and Number	41001		10f. Zip Code		10g.	Citizen of What Co	ountry?
	238 c		1795 Rochester	Street			1114		USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	illed within 72 hours after death with the Maryland Hygiene, the then "natural", or itema 23a or 28a-f ehow ent, Ira Maslical Evandrar must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify: V	Mhite
3	hour	Completed t	15. Decedent's E		16a, Dec	edent's Usual Occupa e kind of work done o	ition	16	b. Kind of Business	
21215-003	n n									
212	d with	ındraisin	g Firm							
D	be filed within 72 hours after death with the Marylan ital Hygiene. ad other than "natural; or itema 23a or 28a-f show other than "natural; or itema 23a or 28a-f show event. In Marilcal Examinar must be notified at	Be (17. Father's Name (First, Middle, Last					e (First, Middle, Ma		
<u>X</u>	should be nd Mental n marked c	10	Louis Herbert				<u>_</u> _	orie Doro		
Maryland	12 sho h and 7 ie mu trauma		19a. Informant's Name/Relationship			ing Address (Street a				1
ď	s 1 and 2 should if Health and Mer Itam 27 is marks other traumatic		Peter W. Coakley 20a. Method of Disposition		0b. Place of Disc	osition (Name of	1 1		c. Location - City or	
<u>o</u>	Pages nent of int: if it		1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	Removal from State		ematory`or other place cematory,)/06 B	altimore.	MT
altimore,	permit. Pages Depertment of I important: if Its eny injury or of		21. Signature of Funeral Service Lice		riectio di	22. Name and Addres	s of Facility Cre	emation Sc		
ñ	Ded in Personal		Edward A. Gre	gorchik		299 Frede				
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the one cause on each line.	deáth. Do not e	nter the mode of dying	g, such as cardiac	or respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Reme	ratin	Fail	w			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):	Fails Tactor				
	± Xuminer	er	Sequentially list conditions,	b. Jun to (u. as a ur	acuence of):	lactor	cer			
Λ.	ted	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 to (6, 43 4 6)	equence ory.	Come				
<u>ب</u> درلا	execu n and ial-tra	Examin	that initiated events resulting in death) Last	c. Due to (or as a co		quoc				
8760,	ficate be executed physicien and is the burial-transit	dical		_ d.						
9	ng ph		IF FEMALE:			***************************************			N A	
Вох	death certifii e attending p id for use as	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of profile 1 Live birth 2	Fetal death 3	□Ectopic pregnancy			23d. Date of de Month	livery Day Year
o.	0 0	by Physician/Me	1 Yes 2 No	4☐ Pregnant at time 9☐ Unknown	of death 5	Other (specify)				
<u> </u>	The law requires that the de ate has been signed by the a page 2 should be detached f	Ph	Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records,	uires tha signed td be del			-				1 🗆 Yes	2 3 No 3 P	robably 4 Unknown
Ö	w requir been si should I	lete						24a. Was an	24b. Were a	utopsy findings available
æ	The lav	Completed						autopsy performe 1 Yes 2	d? prior to death?	completion of cause of
<u>ra</u>	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Deat	h (Check only one)	PNO 10.	2010
<u>></u>	ysician: nis certific I director,	To E	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie		4 Nursing Ho	me 5 Residenc	e 6 □Other (Spe	icify)
0	ding Phy h. After this funeral c		27. Manner 1 eath 1 = atural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time Injury	Work		28d. Describe how	injury occurred	
<u>s</u>	tendi Jeath. tor: A	cat	2 Accident investigation 3 Suicide 6 Could not to		At home - 6		Yes 2 □ No	Off Location /Street	at and Number or O	um I Couto Alumbas
Division of Vital	f or Attendation after deati	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	Specify)	treet, factory, office		City or Town, S	et and Number or R State)	urai Abute Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certifics completely filled in by the funaral director.			hysician: To the best of m						
	n 24 } he Fu	edical	(Check only 2 Medical Exa	miner: On the basis of exa and mapner stated.	amination and/or	nvestigation, in my of	oinion, death occur	red at the time, date	and place, and du	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	-//		29c. License	number	29d	. Date signed (Mon	th, Day, Year)
1			· Cont	42			5 33	00	10 191	XUU
	18		30. Name and address of person who	completed cause of death	(from 23a) (Type	Print) AIN	warli.	< mn	2141	7
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1 .4	ricycli	- 1111	~ 11	
	Regist		OCT 1 0 3	2006	S. S. F.	Jarres				

			1 - For State Registrar	State of M	aryland		artment o			ind M		iene	006	31898
	Physicia	an	1. Decedent's Name (First, Middle, La								2. Date of Deat Month	b Day	2006	3. Time of Death
	/Medic	al	Lawrence W. Ca				4b. City, To	um or i	ocation o		October	_	2006 County of Death	9:40 A M
1	Examin	er	6908 Stratford						ille	Dogui		10.0	Carrol	l
	Funeral Director		5. Social Security Number 6. S		ge (In yrs. lasi	t birthday) Yrs.	If Under 1		If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Pay, April 2	29°,1	9. Birthp Cour Cal	lace (State or Foreign try) ifornia
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Lo	cation						1	0d. Inside City Limits
	Maryi I-f aho	tor	Maryland Carrol	Ĺ		Syk	esvill	_e						1 ☐ Yes 2 💢 No
	or 28s	Sirec	10e. Street and Number				10f. Zip Co		10.1		1	0g. Citiz	en of What Cour	try?
	a 23a	rall	6908 Stratford D	12. Was Decedent	Ever in 11 S	12.1	Nos Decedes	217		nin? /Sne	ofy Ves or No.	1	USA 4. Race - Americ	an Indian
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itema 23a or 28a-f ahow aumatic avant, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?		f Yes, specify	-	Specify:	, Puerto i	city Yes or No- Rican, etc.)		Black, White,	
2-0	72 hor	eted	15. Decedent's E (Specify only highest gr		1	(Give	dent's Usual (done du	uring most	of working	ng	16b. Kin	d of Business/In	dustry
21215-0036	within one. then "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	oo not use Truck I	retired)					Truckir	10
d 2	filed y Hygie other I		17. Father's Name (First, Middle, Las.	')			I dok I			r's Name	(First, Middle, I	Maiden S		.6
Maryland	ould be Mental arked o	To Be	James L. Rau							Juni	e E. Ro	ss		
dan	2 sho and h la ma		19a. Informant's Name/Relationship	(Type, Print)			•					-	Town, State, Zip	
e,	1 and Health am 27 thar t		James Rau, Son 20a. Method of Disposition				STYACI sition (Name matory or othe			-			Maryland	
ρ	ages ant of it: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special		•		matory or othe ematory			10/10				Maryland
Baltimore,	permit. Pages I and 2 should be Depertment of Health and Menta Important: If Itam 27 Is marked any injury or other traumatic av ance.		21. Signature of Funeral Service Use Thomas Gregor	nsee	TICUL	22	Name and	Address	s of Facility	ětv (Of Mary	Land		
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause	d the death.									Approximate Interval Between
P	Pnysician		Immediate Cause (Final disease or condition	a M	Step Step Step Step Step Step Step Step	teti		1	`					Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	s a consequer	nce of):								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or a	s a consequer	nea of):								
, ₍ ,	ate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c										
60 ,	te be executed ysicien and te burial-transit		resulting in death) Last	Due to (or a	s a consequer	nce of):								
68760,	physics the t	edical		_ d.									T	
.O. Box (e death certifice the ettending ph hed for use as tl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	eath 3	□Ectopic preg □ Other <i>(spec</i>					2	3d. Date of delive Month	ery Day Year
<u>α</u>	that the	þ	Part II. Other significant conditions	contributing to death	but not resulti	ng in the u	nderlying cau	se give	n in Part I.			bacco us		ne cause of death?
Š	requ been should	Completed					-				24a. Was a			psy findings available
Rec	The law ate has page 2	duc									autops	sy med?_	prior to co death?	mpletion of cause of
ital	certificat	0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only or	2 2 No 1e)	1 🗆 Yes	0 1
Division of Vital Records,	S S S	ToB	examiner? 1 ☐ Yes 2 ☑ No	-	ient 2 EF				4 140				Other (Special	Son's Residence
ou c	Jing After fune	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, D	ay Year)	8b. Time o Injury	1 280 M	Unjury Work	at ? ′es 2 □		28d. Describe h	ow injury	occurred	
/isi	Attending ir death. actor: After by the fune	fical	2 Accident investigate 3 Surcide 6 Could not determine	28e. Place of Ir		e, farm, st							Number or Rur	al Route Number.
á	s after of in t	Certification:	4 Homicide	building, e	atc. (Specify)						City or Tow	n, State)		
	To the Hospital or Attentwith 24 hours after death To the Funeral Director: completely filled in by the	edicai		hysician: To the bes miner: On the basis and manner s	of examination									
	To the To the To the Comple	Me	29b. Signature and title of certifier	1 A	= 1 1	^	29c. I	License	number		2	9d. Date	signed (Month,	Day, Year)
			Elito /	Culley	100	1)	1	ノマ	522	98	_	0	-07	-06
	b		30. Name and address of person who	er	55	3a) (Type.	Print)	C	ent	er	Stree-	†	Vestmin	storm PS7
	Sta Registi		31. Date filed (Month Cax: Year)	2006 32. Regis	trar's Signatur	The Age	bark							

	1- State of Maryland / Department of Health and M Certificate of Death	Mental Hygie Reg.	
Physician	Decedent's Name (First, Middle, Last) ELIZABETH IRENE DAILEY	2. Date of Death Month	Day Year 3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	CIODE	4c. County of Death ANNE ARUNDEL
Funeral Director	Baltmore Washington Medical Central Glen Burne 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 11 Under 1 Year H Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
the Maryland 28e-f show notiling a	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD ANNE ARUNDEL SEVERN		10d. Inside City Limits 1 ☐ Yes 🏖 No
vith the	10e. Street and Number 10f. Zip Code 21144	10g.	Citizen of What Country?
death ms 23	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	ecify Yes or No- Rican, etc.)	USA 14. Race - American Indian, Black, White, etc.
D & s = 1	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation	168	b. Kind of Business/Industry
_ N n 5 2 3 1 2	(Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 TH (Give kind of work done during most of work life. DO NOT use retired) TEACHER'S AIDE		BALTIMORE CITY PUBLIC SCHOOLS
The Be fill Had out out out out out out out out out out		e (First, Middle, Mai CHA POTTS	
Maryla do 2 should the and Mer the and Mer traumatic traumatic To	19a. Informant's Name/Relationship (Type, Print) ALPHONSO DAILEY / HUSBAND 1410 ILLINOIS AVE		
DALLEY altimore, M mit Pages 1 end 2 pariment of Health portent: if item 27 y injury or other tre	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 200	c. Location - City or Town, State ANOVER, MD
Baltimor Permit Pages Department: If the Importent: If the any injury or or sonce.	21. Signature of Facility HOV	WELL FUN	ERAL HOME 21207 E, BALTIMORE, MD
Physician /Medical Examiner	23a. Pally Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of):	or respiratory arrest.	
icate be executed physician and the burial-transit circal Examiner	Sequentially fish conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	~	6WK
vision of Vital Records, P.O. Box 6i Attending Physicien: The law requires that the death certific r death. e-tor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as: iffication: To Be Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Ectopic pregnancy 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
rds, P quires that on signed to uid be dett	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobad	co use contribute to the cause of death? 2ÀNo 3□ Probably 4□Unknown
Division of Vital Records, tor Attending Physicien: The law requires that retent Attending Physicien: The law requires that retent Attending the centificate has been signed in by the funeral director, page 2 should be deriffication: To Be Completed by		24a. Was an autopsy performer 1 ☐ Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
of Vita hysicien: his certific li director,	examiner?	th <i>(Check only one)</i> ome 5 🗆 Reside <i>nc</i>	e 6 □Other (Specify)
ion of nding Ph ath. T: After the funeral ation: 1	27. Manner of eath 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	28d. Describe how	injury occurred
Page 1	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
Hospi 4 hour Funer ely fill	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the caus red at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
To the I within 2. To the I complet	29b. Signature and Hitle of certifier 29c. License number) _	Date signed (Month, Day, Year)
	30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)	66 8	chie, N. 2106/
State Registrar	61. Date filed (Month, Day, Year) 2006 32 Registrar's Signature	VAN DU	(h18)/4- 2/001

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:45 P M Jane S. Dorman October 6. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Edenwald Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | 14/11/2/1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√□ F 88 120-10-5352 New York Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic svent, it a Medical Examination must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Baltimore Towson 10e. Sfreef and Number 10f. Zip Code 10g, Cifizen of What Country? U.S.A. 800 Southerly Road, Apt. 1808 21286 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bfack, White, etc. 1 ☐ Yes 2 ☑ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Samuel M. Strasburger Bess A. Adler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Waters, Daughter 3750 Pinebrook Circle, #207 Bradenton, FL 34209 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Dulaney Valley 10/09/2000 1000011, ...

Memorial Gardens

22. Name and Address of Facility Ruck Towson Funeral Home, INc. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service Licensee any Ir argas 1050 York Road, Towson, MD 21204 Part I. Enter tile of sease, or conplications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or he set liure. List of one cause on each line. Approximate Interval Between immediate Cause (Finaf disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transk Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as (IF FEMALE: 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Š Part If. Other significant conditions confributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 □Unknown cete has been sig page 2 should b 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe After this certificate has 1□ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 No P 1 Inpafient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification; Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certiff 29c. License number 29d. Date signed (Month, Day, Year) eted cause of death (ften 23a) (Type, Print) Albushne 32. Registrar's Signature 31. Date filed (Month Da State Registrar

State of Maryland / Department of Health and Mental Hygien 1 - For Stete Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 6, 2006 Year **Physician** 5:58 A M Kramer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 6818 Barnett Road Glenmont if Under 1 Year | II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 3, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🖫 F 58 266-96-7099 1948 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State or Itams 23a or 28e-f show 1 ☐ Yes 2 X No Baltimore Glenmont Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Importent: If fam 27 is marked other than "natural", or itams 23a or 2, any injury or other traumatic event, Ita Madical Examinar. TISA 21239 6818 Barnett Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Dental Office Office Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dorothy Atwood Walter Kramer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6818 Barnett Road Baltimore, Maryland 21239 Husband Robert K. Drain 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Catonsville, Maryland 10/07/2006 Metro Crematory • 4 ☐ Donation 15 ☐ Other (Specify) 21. Signature of Foneral Service Licenses 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Severe COP Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury Due to (or as a consequence of): Examiner burial-transit certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medlcal the t use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 ☐ Yes 2 **N**0 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 9 this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death e Hospitel or Attending Pl 24 hours after death. e Funeral Diractor: After tl Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) determined 4 Thomicide 24 hours a 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 00063180 6.2000 MD mun 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bulmuse Murles N 4701 reenan Conco F 32 Registrar's Signature 31. Date liled (Month, Day, Year) State 2006 Registrar

DHMH 17 Rev 1/2001

RESTON DISNEY

Sean Dill 06-07501 UNK UNK

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dill 2207 hrs Medical Examiner Sean October 4, 2006 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) NA Baltimore Johns Hopkins Hospital If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs last birthday) **Funeral** Days Months Hours Director 213-82-1202 Country) 1 X M 2 F 06-14-1974 Md Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State 10b. County 1 X Yes 2 No or items 23a or 28a-f show must be notified at once. Md. NA Baltimore death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2809 Ashland Avenue 21205 USA Funera 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 XNever Married 2 Married 1 Yes Specify Black hours after 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed other than "natural", the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) es I and 2 should be filed within 72 h of Health and Mental Hygiene. If item 27 is marked other there "... Baltimore, MD 21215-0036 12th grade Unemployed NΑ 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Dill Rosalyn Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 1206, Balto., 20c. Location - City or Town, State Lillian I. Gooden 124 W. Franklin Street Greatgrand-mother 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) or other 1 Burial 2 X Cremation 3 Removal from State Pages Greenmount Cem. Baltimore, Md. artment c Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East la 1101 E. North Avenue, Baltimore, 21202 Md. CA 23a, Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED The law requires that the death certificate be Box 68760 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year 1 Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown for Unknown detached 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be be deta ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has death? performed' certificate page Yes 2 ✓ Yes No 26 Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be examiner? DOA Nursing Home 5 Residence 6 Inpatient 2 FR/Outpatient 3 this ဥ 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) Oct 4, 2006 28d Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Manner of Death Certification: Subject shot 2140 hrs Natural Yes 2 🗸 No Director: Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide 1200 blk Luzerne Avenue, Baltimore, MD determined (Specify) Sidewalk To the Funeral 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number O.C.M.E. October 5, 2006 Missa rassel 30. N me and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 CCT Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrer 31904 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October **Physician** 6:52 PM 2006 Tamara J. Dobson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F Months 62 212-46-3554 Director 5-14-44 Md Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow eny injury or other treumatic event, the Medical Example at must be published at ODGs. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State NE Yes 2 No Director Baltimore Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 2300 W. Mosher Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Motion Pictures Artist 12th grade 4 Yrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dobson Evelyn Russell Melvin Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister 2300 W. Mosher Street, Baltimore, Md. Darilyn Evelyn Dobson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. Greenmount Cem. 10-9-06 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East Jums 1101 E. North Ave., Baltimore, Md. 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final End-Stage multiple oclerosis 15 years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the attending physiclen and hed for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown been : 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has 1 Yes 2 No or Attending Physician: tor; After this certific the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 No 2 R/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 Yes 2 No investigation efter death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours e To the Funerel C 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ▶7. Jeadelle Mac thear mo October 2, 2006 113657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARGREGOR, 700W 40th STREET, BALTIMORE, MD 21211 N 18 MELLE 32 Registrar's Signature 31. Date filed (Month, Day, Year) OCT 1 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Donatelli, Jr. Joseph Anthony 02:10 a.m October 04. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manor Care Dulaney Towson Baltimore Co. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 08/30/1965 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 41 218-62-9436 Yrs. Mary Tand Director Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Modical Examinar must be notified at Maryland N/A Baltimore 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 2717 Beechland Avenue U.S.A. death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. Int if item 27 is marked other then "neturel", or its 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph A. Donatelli, Sr. Helia Lee Boeh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helia L. Donatelli - Mother 625 Lorca Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) Gardens of Faith Oct.10,2006 Rossville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Encephalopathy **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner deeth certificate be executed ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ cete has been sign, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attending Physicien: Be 25. Was case referred to medicat 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 E. Timoniumrd. Suite # 209 Timonium, MD 21093 Asadi Cyrus 31. Date filed (Month, Day, Year) 32. Adgistrar's Signature State 1 0 2006 Registrar

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Ma	aryland / Depa	artment of H rtificate of L			iene •9. No 2006	31907
	Physici /Medic		1. Decedent's Name (First, Middle, Las ARTHUR	•	VANS			2. Date of Deat	Day Year	3. Time of Death 8:30avm
	Examir		4a. Facility Name (If not institution, give	Road			ndalk		4c. County of Deal	
K	Funeral Director			9X 7. Age	9 (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) 9. Birth Co	hplace (State or Foreign ountry) MD
	Aaryland f ahow	or	Usual Residence of Decedent 10a. State 10b. County MD N/A		10c. City, Town or Lo	cation Saltimore	۵			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the ? 3a or 28a-	Funeral Director	10e. Street and Number 600 Light St.	Apt 302		10f. Zip Code		1230	0g. Citizen of What Co	1
36	72 hours after death with the Maryland natural', or items 23a or 28a-1 ahow diest Examiner musi e notilied al	by Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 ☐ N If Yes, Give Year or Dates:	Army	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	be filed within 72 hour ital Hygiene. Id other than "natural event, Ira Medical Er	Completed t	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation	16a. Dece (Give life.	dent's Usual Occupa kind of work done a DO NOT use retired,	luring most of wor	king	16b. Kind of Business/	Industry
Ind 21	be filed with hygier of other the event, In	Be	6 17. Father's Name (First, Middle, Last) John T. Evans	0		Pa	_	ne (First, Middle, M		2
Maryland	and Mer e marke	10	19a. Informant's Name/Relationship (7 Albert M. Evar			_	and Number or Ru	ıral Route Number,	City or Town, State, 2	
altimore, I	es 1 and of Healt fitem 2 r other		20a. Method of Disposition 12 Marrial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	20b. Place of Dispo	sition (Name of matory or other place	9)	Date	ltimore N 20c. Location - City or 6 Crowns	Town, State
Baltir	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen		2 2	Name and Address	s of Facility		eral Home	
	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause of each lin	the death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
8760,	death certificate be executed Medical	dical Examiner	Sequentially list conditions, flary, lacong to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a	a consequence of): a consequence of): a consequence of):					
.O. Box 6	death certific e ettending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of the first term of the f	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
<u>α</u>	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions or	ontributing to death bu	ut not resulting in the u	nderlying cause give	on in Part I.		s 2 No 3 Pr	the cause of death?
Vital Records,	The ete h page	Completed						24a Was ar autops perform 1 Yes 2	v prior to o	itopsy findings available completion of cause of 2 \(\sum \text{No} \)
of	Attending Physician: Thr death. ector: After this certificete by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner eath 1 atural 5 Pending investigation	Hospital: 1 Inpatier 28a. Date of Injur (Month, Day		28c. Injury Work	1. 4 Nursing H	ith (Check only one one 5 Reside 28d. Describe ho		House
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number.
	To the Hospital or within 24 hours after to the Funeral Discompletely filled in	edical	one) 2 Medical Exam	ysicien: To the best of iner: On the basis of and manner sta	examination and/or in	vestigation, in my op	inion, death occu	, and due to the ca rred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To the vithin 2 To the complete	Σ	29b. Signature and title of certifier	20		29c. License	1587	22 a	od. Date signed (Monti	1, Day, Year)
_	1		30. Name and address of person who o	BOBN	10 25	Mai	Stipe	ov 2	1136	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 0 2	006 32. Registra	ar's Signatura	bendi				

			1- State of Maryland / Registrar		rtment of H			ene 00 (5 31908
	Physici	an.	Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	/Medic		Doris Anna Ende				October	^{Day} , 2006	
ı	Examin	er	4a. Facility Name (If not institution, give street and number) 1349 South Seneca Rd.		4b. City, Town, or Middle	Location of Death River		4c. County of De Balti	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F 86 1 M 2 M F 86	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 7, 1	Year)	Birthplace (State or Foreign Country) aryland
	and aw		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Loc	ation				10d. Inside City Limits
	Maryl -fehc	tor	Maryland Baltimore Mide	dle F	River				1 ☐ Yes 2½ No
	r 28a	Directo	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?
	23a c		1349 South Seneca Rd.		2122	0		USA	
036	2 should be filed within 72 hours after death with the Maryland and Mentle Hygiene, and Mentle Hygiene, is marked other than "natural; or items 23a or 28a-f ehow aumatic event, the Marylan Engistrant must be nutified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 \(\text{Mwidowed} \) 4 \(\text{Divorced} \) Divorced	i i	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify: Wh	
20	72 ho	eted	15. Decedent's Education 16 (Specify only highest grade completed)	a. Decede	ent's Usual Occupa and of work done of ONOT use retired	ition Juring most of work	kina 1	6b. Kind of Busine	ss/Industry
21215-0036	within 72 ene. than "nat	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		ONOT use retired)		Own Home	
	tiled Hygie other	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, M	aiden Sumame)	
/lan	should be ind Mental i marked o umatic eve	To B	John Adam Deppisch			Martha 1	Denn		
, Maryland	コモトン						ral Route Number, Baltimore		
Baltimore,	of H		1 OXPuriat 2 Compation 2 Demoust from State Cemet	ery, crem	ition (Name of atory or other place 1 Mem. Gar	9)		Oc. Location - City Baltimore	or Town, State , Maryland
Balt	permit. Page Department of Important: If eny injury of		21. Signifure of Funeral Service Opensee W. Burkouske	14			l Home P. venue Ess		land 21221
8760,	cate be executed /Medical Examiner the burial-transit	dical Examiner	23a. Fast 1. Enter the disease, or complications that caused the death. Do spock, or heert failure. List only one causable each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions of the	e of): e of):	(A)	ER (p	IR C; NC	>HA	Interval Between
O. Box 6	the death certifi y the attending iched for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
ds, P	9 P 6	Ď	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause give	en in Part I.			to the cause of death? Probably 4 DUnknown
Hecords,	o - C 0	Completed					24a. Was an autopsy	prior !	autopsy findings av Illable to completion of cause of
_	ician: Th certificete rector, pag	ပို	25. Was case referred to medical			26 Place of Deat	1 ☐ Yes 2	2 No 1 □ Y	es 2 No
	S 0 5	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	Outpatient	3□ DOA Othe	r	ome 5 Residen	nce 6 Other (S	pecify)
	ding Phy h. After thi funeral		1. □Natural 5 □ Pending (Month, Day Year)	Time of Injury	28c. Injury Work	at ? ∕es 2 □No	28d. Describe how	v injury occurred	
Division	or Attending efter death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, the building, etc. (Specify)	farm, stre		55 2 2,10	28f. Location (Stre City or Town,		Rural Route Number,
	e Hospital or Al 24 hours effer o Eunerel Direc letely filled in by	edicalC	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge and manner stated.	ge, death und or inve	occurred at the timestigation, in my op	e, date and place, inion, death occur	and due to the cau red at the time, dat	use(s) and manner te and place, and d	as stated. lue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and with of certifier		290 License	number /5	290	d. Date signed (Mo	inth Day, Year)
	1		30. Na address of person who computed cause of down its m 28a	Пур	J/Re	DR- 7	ouso	as por	21704
	Sta Registr		31. Date filed (Month Cox Year) 0 2006 32. Registrar's Signature	1 1	osell)				И

06-07529 Arianna Elter

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		Certificate o	Death		Reg. No.	2000	5 3190
Physician Medical Examine					2. Date of Month	Day	Year	3. Time of Death 0335 hrs
	4a. Facility Name (if not institution			4b. City, Town, or Locatio		er 6, 2006	. County of Death	
	Johns Hopkins Hospi	al		Baltimore				
Funeral Director	5. Social Security Number 220–75–9803	6. Sex 7. Age (In 1 M 2 F	yrs. last birthday) Yrs	Months Days Hou	urs Min. Aug	of Birth(MM/I ust 15	DD/YYYY) 9. Birth Foreign Cou	nplace (State or Maryland Intry
any	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Locat	ion				10d Inside City Limits
* .	MD 10e. Street and Number		В	altimore		10- 00-		1 X Yes 2 No
ith the Maryland 23a or 28a-f sh notified at one				21218			USA	<i>,</i>
or items	3 Widowed 4 Div	12. Was Decedent Ever arried Armed Forces? 1 Yes 2 X orced If Yes, Give Year or Dates:	No If Y	s Decedent of Hispanic Ces, specify Cuban, Mexicon Yes 2 No specify	an, Puerto Rican, etc	:.)	14. Race - Americ White, etc. Specify: Blo	
2 3 🗐 🕏		College (1-4 or 5+)	during m	t's Usual Occupation (Givost of working life, DO NO NEWER Work	OT use retired)	16b. K	and of Business/In	dustry
	Garrett E	ner's Name (First, Mid Verlinda	Kara	Morefi				
MD nd 2 sho slith and m 27 is aumati	19a. Informant's Name/Relations Garrett Elte	r-father	3100	Address (Street and N Louise Av	venue-Ba	ltimo:	re,MD 2	1214
Baltimore, Normit Pages I and Department of Healt Important: If item njury or other tran	20a Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Sp	3 Removal from State	crematory or othe Moreland Mer	rorial Park	10-10-		ocation - City or Tarkvill	
Baltimoc permit Page Department of Important:	21 Signature of Funeral Service	1=fadol	The state of the s	ame and Address of Faci 00 Harfor arkville.	MD 21234	(AL CHAP CREMATI	EL AND ON SERVICES
Physician /Medical	23a. Part I. Enter the disease, or failure. List only one cause	on each line.	leath. Do not enter th	ne mode of dying, such as	s cardiac or respirato	ry arrest, shoo	ck, or heart	Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Sudden unex 1. Due to (or as a consequent		<u>infancy (SUDI)</u>				Death
Į.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequer	nce of):					
ted insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer	nce of):			· ·		
8760, ificate be executed g physician and s the burial - transi	X UNPENDED	AMENDED #220	27 20- 6	-ME -062 107	/7 /0¢ mm			
8760, tifficate bring physic as the burnary	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of	pregnancy	erME, g862, 12/		23d	Date of delivery	
). Box 68760, the death certificate be execu- by the attending physician annoted for use as the burnal - tra- Physician/Medical	past 12 months? 1 Yes 2 No 9 Unk	e 1 Live birth 4 Pregnant at time	of dooth	al death 3 Ector	pic pregnancy		Month Da	ay Y ear
P.C es that es that igned be determined.	3	ons contributing to death but	not resulting in the u	nderlying cause given in I			se contribute to th	ne cause of death?
of Vital Records, g Physician: The law require vier this certificate has been signered if rector, page 2 should b. To Be Completed			_			Was an autopsy performed?		psy findings available impletion of cause of
tal Reco				26 Place of Deat	1 🗸	res 2 No	1 Yes	2 No
Vital ystcian: his certif director,	examiner?	Hospital: 1 Inpatient 2	2 ✓ ER/Outpatient		Nursing Home 5	Residen	nce 6 Other:	
After t	27 Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Ir			ribe how injur	ry occurred	
ivisior or Attend after death Director: I in by the Itel	1 Natural 5 Pend 2 Accident Inves	tigation Fnd 10/6/200			A UIKI	10WI		
Division of spital or Attending tours after death the real Director: Aft filled in by the func Certification:	1.011110100	a not be of Injury - (Specify) resid		t, factory, office building,	or To	ion (Street an wn, State) 1(more - M	608 Abbotsi	l Route Number, City ton Road
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		ysician: To the best of my knowniner: On the basis of examination and manner stated	wledge, death occuri ion and/or investigati	ed at the time, date and pon, in my opinion, death o	place, and due to the	cause(s) and	manner as started	d cause(s)
Ž	SULLY			29c License number O.C.M.E.	er		ate signed (Month ber 6, 2006	ı, Day, Year)
		Ssistant Medical Exami	ner 111 Pen	Street, Baltimore,	MD 21201			
State Registra	6 7 7 9 9	2006 32. Redistrar's Sig	gnature Apr	w/L				

			1 - For State Registrar	State of	Marylaı		artmen rtificat			and Me	ental Hyg	jiene eg. No.	2006	31910
I	Physici		1. Decedent's Name (First, Middle,	Last)						2	Date of Dea Month	th Bay	2 <u>%</u> %	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution,	give street and num			, ,		Location o			4c.	County of Deat	h
				y Schnau Sex 7		3P1712	If Under		If Under 2				HOWA	-
H	Funeral Director		5. Social Security Number 538–30–5334	. Sex 1⊠M 2□F	7.2	last birthday) Yrs.	Months		Hours	Min.	3. Date of Birth (Month, Day 08 / 17 / 1	Year) 1934	9. Birt	hplace (State or Foreign nuntry) MN
	pug .		Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or Lo	ocation							10d. Inside City Limits
	Maryis -f eho	ţŏ	MD Anne An	undel		evern	30411017							1 ☐ Yes 2 No
	or 288	Oirec	10e. Street and Number				10f. Zip				1	0g. Citiz	zen of What Co	-
	s 23a	rail	7943 Trafalgar (lourt	lant Francia I	15 12	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		21144	-:-0 (0:	4. V No		USA 14. Race - Ame	
036	ours after de rel', or item Examinar	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Ford	es? 2 □ No		was Deced If Yes, spec		spanic Orig n, Mexican Specify:	jin? (Speci , Puerto Ri	ify Yes or No- can, etc.)		Black, White	e, etc.
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene d other then "naturel", or items 23s or 28s-f ehow event, the Medical Exorcinal must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1.2		4or 5+)	(Give	dent's Usua kind of wor DO NOT us	rk done d se retired,	ation luring most)	of working	7		overnme	
	filed with Hygiene.	Be Co	17. Father's Name (First, Middle, La	st)		1 0000	- I IIIIICI	10	18. Mothe	r's Name (First, Middle,			
Maryland	should be and Mental s marked o umatic eve	To B	Orlando J. Enger								osephse			
Mar	CI		19a. Informant's Name/Relationship Mrs. Janice M. I		ife						Ro <i>ute Nu</i> mbei evern,		Town, State, 2 21144	Zip Code)
ë,	ss 1 and of Heelth item 27 other tr		20a. Method of Disposition		20b.	Place of Dispo cemetery, crei				Dat			cation - City or	Town, State
Baltimore,	Pages tment of t		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	city)		ryland	Vets.	Cen	n. 1				wnsvill	
Ra	permit. Page Department of Important: If any njury or ance.		21. Signatore of Funeral Service Li	enset // /	Maizi	/					_		eral Ho MD 210	
			23a. Part 1. Enter the disease, or conshock, or heart failure. List or	emplications that ca	used the dea	()								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		TIC	SIFOCK								Onset and Death
E	/Medical Examiner		resulting in death)		r as a consec	quence of):	M.T.	r	RIG		مهردرة	_		12 0000
4	7 -	ner	Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consec	quence of):					المرابعة	-		
V	be executed icien and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last		r as a consec	BUTS	Ric	7117	AM	WE.				S& DAYS
3/60	ate be executed hysicien and the burial-transit	ical E		d.										
و	artificating physe as th		IF FEMALE:											
O. Box	the death certificate y the attending phys iched for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta nt at time of d	al death 3	Ectopic pro Other (sp					2	3d. Date of del Month	ivery Day Year
ecords, P.	The law requires that the date has been signed by the bage 2 should be detached	5	Part II. Other significant condition:			sulting in the u	nderlying ca	ause give	n in Part I.			bacco u		the cause of death?
	sicien: The law re certificate has bei irector, page 2 sho	Completed	GRANIC KID	ney dis	.EA32						24a. Was a autops perform	ned?	prior to death?	topsy findings available completion of cause of
Vital H	sicien: certifica irector.	Bec	25. Was case referred to medical examiner?					1		of Death (Check only on			
ō	g Phy er this	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigal	28a. Date of (Month		ER/Outpatier 28b. Time of Injury		8c. Injury Work	4 🗆 1901	28	5 ☐ Reside d. Describe ho		Other (Spec	sify)
DIVISION	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determina	28e. Place of building	f Injury - At h g, etc. (Speci	ome, farm, str fy)	eet, factory	, office		28	f. Location (St City or Town			iral Route Number,
	the Hosp in 24 hou the Funer ipletely fill	edicai	(Check only 2 Medical Ex	Physician: To the bas aminer: On the bas and manne	is of examina	owledge, deatl ation and/or in	vestigation,	in my op	inion, deat	d place, and h occurred	at the time, d	ate and	place, and due	to the cause(s)
	S T Will	Σ	29b. Signature and title of certifier					License			1		signed (Monti	
	1		1		of death (Ite	п 23a) (Tvoe			974				8 20	
	N		DAVID UINYANTE	m mo ic	724	LITTIE	FATI	KEN	TPA	PKNI	AU C	su »	nbit n	no 21044
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 0 2	006 Re	gistrar's Sign	Inte Apr	ale)							

State of Maryland / Department of Health and Mental Hygiene 2006 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10.53PM **Physician** Kajos /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore NA Good Samaritan N.H. If Under 1 Year | If Under 24 Hrs. | 8. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** M 2□F Yrs 068-24-8151 75 Director Va 12-19-1930 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23s or 28e-1 show any Injury or other treumatic event, fra Medical Examilian Intuition and once. 1 XYes 2 No Director Baltimore Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21206 4609 Mannasota Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: Black þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) B G &E 6th grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elliott Lilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 4609 Mannasota Avenue, Baltimore, Md. Eva M. Elliott Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10-6-06 Dundalk, Md. Trinity Cem. 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 21202 1101 E. North Ave., Baltimore, Md. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) ed by the ettending physicien and deteched for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 ☐ Other (specify) s been signed by the should be detected Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy perform 2 No efter death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 21X No Other: ဥ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funarel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only To the elelle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) doel 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

		1 - For State Registrer	State of Maryla		epartment of F Certificate of			Reg. No.	31912
Physicia /Medic		Decedent's Name (First, Middle, La RIS EBA	44GH				2. Date of De Month Octobe	r 200	3. Time of Death
Examin Funeral Director			ton Medical Color of the Age (In yrs	enter last birth	Glen F day) If Under 1 Year Months Days	or Location of Death OLLY NE If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March I	th Year) 935 Ma	hplace (State or Foreign untry) ryland
the Maryland r 28e-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar			or Location lenton				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
<u> </u>	ai Director	10e. Street and Number 1315 Chapelview	Drive		10f. Zip Code 2111	3		10g. Citizen of What Co	ountry?
ĕ 2 ≅	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	U.S.	13. Was Decedent of H If Yes, specify Cub		ecify Yes or No Rican, etc.)	9- 14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036 sd within 72 hours atter giene. The Traturel; or Ite the Medical Esamine.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12)	ducation ade completed) College (1-4or 5+)	- (Decedent's Usual Occup Give kind of work done life. DO NOT use retire Memaker	pation during most of work d)	sing	16b. Kind of Business	Industry
land 2 ld be filed ental Hygi ked other	To Be Co	17. Father's Name (First, Middle, Last Raymond Watki						, Maiden Sumame) arris	
imore, Maryla Fages 1 end 2 should ment of Heelith and Men ant: if item 27 is marke, ury or other treumatic.		19a. Informant's Name/Relationship (Sherry Lynn Ebau	gh - Daughter	1	315 Chapely	view Drive	ra <i>l R</i> oute Numb e Odent	er, City or Town, State, I ton, Marylai	nd 21113
Page nt: #		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Signature) Fynegal Service (Special Service)	fy) 0a	ık La	Disposition (Name of crematory or other pla Wn Cemeter)	/ 10/09	Date 9/2006	Baltimore, Bos Harford	Maryland
Balti permit. Depertm importa eny inju		23a. Part1. Enter the disease, or comshock, or heart failure. List only			Leonard C	J. Ruck,	Inc. Ba	altimore, Ma	Approximate Interval Between
Physician /Medical Examiner be executed by physicien and es the purial-transit	edical Examiner	Shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	equence of	obstraci	time per	lung	assa	Onset and Death
Box 6 eath certif	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown	23c. If yes, outcome of preging the preging the pregnant at time of the pregnant at time at ti	tal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of de Month	livery Day Year
Cords, P.(w requires thet the been signed by should be detection.	þ	Part II. Other significant conditions	contributing to death but not re	sulting in	the underlying cause gr	ven in Part I.	10		robably 4 Unknown
Vital Rec	e Completed	25. Was case referred to medical				26. Place of Dea	1 Yes	psy prior to death? 2 € No 1 □ Yes	utopsy findings available completion of cause of
On of ding Phys h. After this	ation: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Zertural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Ti	me of 28c. Injury Wo	her: 4 🗆 Nursing H	ome 5 Resi	idence 6 Other (Spe how injury occurred	icity)
Division Hospitel or Attence A hours effer death Funeral Director: tely filled in by the i	Certification:	3 Suicide 6 Could not be determined	building, etc. (Spec	cify)			City or To	(Street and Number or R wn, State)	
Divi To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medical		hysician. To the best of right miner: On the basis of examinand manner stated.	nation and	/or investigation, in my	opinion, death occur se number	rred at the time,		e to the cause(s)
Sta Registr	ar	31. Date filed (Month, Day, Year)	305 Hg 32. Registrar's Sign	nature	Soul Dr Si	ite 30:	s d	en Burun	E MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 006 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 10:15 A.M **EVELYN** FEENEY OCTOBER 2006 7, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Mar. 7, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□ M 21 F 90 Yrs. 1916 Maryland Director 220-07-3796 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County itam 27 is marked other then "natural", or Itams 23a or 28e-f show other treumatic event, it is Modical Examinar must be notified at Harford Fallston 1 ☐ Yes 2 No Md. Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21047 U.S.A. 403 Wilgis Road death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: 호 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene ent: If item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) can company line worker 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ann Louise Cavangh John Blinke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 403 Wilgis Road, Fallston, MD 21047 Sandra Feeney/dgtr-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ō permit. Page Department of Importent: If any injury or once. 10/12/2006 Baltimore, Md. * 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 22. Name and Address of Eacility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licens 610 W. MacPhail Road, Bel Air, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) coson /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of): Examiner Tany leading to immedicause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical as signed by the attending the detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown leted 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has Comp autopsy performed 2 No 2 No 1 Yes Division of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours af To the Funerel D completely filled i Hospital 29a. Certifier XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number Java ST 032215 Derobers 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (*Month, Day, Year*) **0CT 1** 0 2006

DR. DAVID DUNN



615 W. MACPHAIL ROAD



BEL AIR, MD.

31914

			1 - State Registrar					Cer	tificat	e of I	Death			Reg. No.		
			1. Decedent's Name (First, Min	idle, Last)	-								2 Date of D	eath		3. Time of Death
	Physic /Medi		Irene Ollie Fo	ad									Octobe	r 6	2006	8:10 PM
7	Exami		4a. Facility Name (If not institu Doctor's Comm				ariilg		4b. City,		Location of			4c. Co	unty of Deat	
	Funeral Director		5. Social Security Number 249-38-1107	6. Sex	/ 2 % F	7. Age	(In yrs. last b	virthday) Yrs.	If Under Months	n 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	nth 57 1925	9. Birti	hplace (State or Foreign untry)
	D.		Usual Residence of Decedent								1					
	Marylan	ctor	MD 10b. Cour	ity ice Ge	orge	s	10c. City, To		cation							10d. Inside City Limits 1 XYes 2 ☐ No
	h with the	ai Director	10e. Street and Number 4105 New Haves	Dr.					10f. Zip	716-					of What Co	,
	be filed within 72 hours after death with the Maryland tial Hyglene. Id other then "naturel", or items 23a or 28a-1 ehow event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ N 3 ☑ Widowed 4 □ Divorce	arned	Armed F	Forces? 2 No Bive	ver in U.S.	11	Vas Dece Yes, spe	cify Cuba	ispanic Ori n, Mexicar Specify:	n, Puerto I	ecify Yes or N Rican, etc.)		Race - Ame Black, White ecify:Bla	9, etc.
	"nature	leted l		ent's Educa	tion		16	(Give	ent's Usua kind of wa	rk done d	<i>furina</i> mos	t of workin	ng	16b. Kind Priva	of Business/ te	Industry
	filed within Hygiene.	Completed	Elementary/Secondary (0-12		College	(1-4or 5+	-) с		dian	s <i>e retired</i>			, Pr			
	should be fit nd Mental Hi marked oth matic even	To Be	17. Father's Name (First, Midd Jasper Moore	e, Last)							18. Mothe Elsi		(First, Middle trong	ə, Maidən Su	mame)	
	of 2 sh lith and 27 is m r traum		19a: Informant's Name/Relation Valerie A. Mil			ild							ie, MD			lip Code)
	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		noval fror	n State	_	ery, crem	natory or c	ther plac	ory I		Öct 10 2006		ion - City or ville,	Town, State Maryland
	permit. Page Department Important: If any Injury or once.		21. Signature of Funeral Servi	Licensee	um	Mo	0382						tion Se r Sprin		yland :	20910-
			23a. Part1. Enter the disease, shock, or heart lailure. L	or complica	tions that	caused t	he death. Do	not ente	er the mod	le of dyin	g, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	(a.		o (or as a	consequence	of):	Hh	1	Broil	n	7. Fo	rge (VA	
1	certificate be executed ding physicien and see as the burial-transit	/Medical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b c. d.			consequence								1.0	
		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	230	1 □ Live	birth 2 gnant at ti	f pregnancy Etel deat ime ol death		Ectopic pr Other (sp					23d	Date of deli Month	very Day Year
	The law requires that the death sie has been signed by the atter bage 2 should be detached for u	þ	Part II. Other significant cond	fibri			not resulting	in the un	derlying c	ause give	n in Part I.			tobacco use		the cause of death?
		Completed	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	· ····································				-					24a. Whas auto perfe 1 ☐ Yes	psy ormed?	4b. Were au prior to c death? 1 ☐ Yes	topsy lindings available ompletion of cause of
	icien: Th certificete rector, pag	Be	25. Was case referred to medi examiner?									of Death	Check only	-		
	Phys this aldii	5	1 Yes 2 No 27. Manner of Death	Hos	pital: 125 28a. Date		t 2□ER/O	utpatient Time of			4 🗀 Nu		ne 5 ☐ Resi			ufy)
	Attending in death.	ţ	1 ☑Natural 5 ☐ Pen	ding stigation	(Mo	nth, Day	Year)	Injury	M	8c. Injury Work	?`` ⁄es 2 🔲 !		.ou. Describe	now injury of	curred	
	II or Attendi after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Cou	d not be mined	28e. Plac buil	e of Injur ding, etc.	y - At home, I (Specify)	arm, stre	et, factory	, office		2	81. Location (City or To	Street and N wn, State)	umber or Ru	ral Route Number,
	with a strenging with a strenging with a strength or the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certification Construction 1 Medical Certification 2 Medical Medical Medical Certification (Construction Certification Certif	ring Physic al Examine	ra On the	ne best of basis of e nner state	examination a	je, death nd/or invi	occurred estigation,	at the tim , in my op	e, date and inion, deal	d place, a th occurre	nd due to the	cause(s) and date and pla	I manner as ce, and due	stated. to the cause(s)
	with	Me	29b. Signature and title of certi	ier Ω	10/	' N	m			. License		15'	7	29d. Date si	gned (Month	Day, Year)
	2		30. Name and address of person						Print)	IDL		C	04 3	OCIU	vei	9,2006 m,mD, ²⁰⁷⁰ 0
	Sta		HITESH V	ur)	32.	8 / (S Signature	ood	Lu	CK	Kd.	Ju.	1430	W. Lc	unha	m, MD, 070
ادرا	Regist		0C	102	2006	139	Sele 1	U.	Dies	BED.						
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ORIGINAL

amend itime 26 Maryland Co. 260 michi 10 Health and Mental Hygiene Certificate of Death Reg. No.2 0 0 6 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. 28 Day 2006 Year **Physician** HENRY EDWARD FAJKOWSKI, SR. 8:05 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4807 Band Hall Road Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 12, 1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1**Ϫ**M 2□F 217-03-7027 86 Yrs. Poland Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location r then "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Director MD **Baltimore** 1 ☐ Yes 2 No Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4316 Flint Hill Drive, #103 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours efter 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No þ If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mentel Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Butcher **Retail** filed item 27 is marked other other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be to ment of Health and Mentel I ant: if item 27 is marked or Joseph Fajkowski Stephanie Levondoski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9407 Perry Hall Blvd., Balt., MD (Son) 21236 Henry E. Fajkowski, Jr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
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important: if ite
eny injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Lake View Memorial 10/2/2006 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Loring Byers Funeral Directors, Inc.
8728 Liberty Road, Randallstown, MD Weldo G 21133 CINIII RYS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Chronic obstructure resulting in death) /Medical Due to (or as a consequence of): DISCUSE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner sicion and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 been signed by the attending phys should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3. Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 hes autopsy performed? certificete 2. No 1 ☐ Yes or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home The Sidence 6 Nother (Specific Specific ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred esidence 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours aftar death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 029085 Ocheben 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5310 Allen T-Court Read 21133 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 1 0 2006 Registrar

DHMH 17 Rev 1/2001

		-	For State	, ,	f Marylan	d / Depa	artment o		and M	lental Hyg	giene Reg. No. 20	06	319	316
			Registrar 1. Decedent's Name (First, Middle,	Last)						2. Date of Dea	ath		3. Time of	f Death
	Physicia	an	Marguerite	Α.	Ŧ	owb1e				Month	6 2006	Year	03:3	7 A M
	/Medic		4a. Facility Name (If not institution,			0.020	4b. City, To	wn, or Location		OCTOBEL	4c. County		1.11.1	- A
	Examin	eı	Greater Baltim			er	Tows	nn			Balti	more		
-	Funeral			6. Sex	7. Age (In yrs. I		If Under 1		er 24 Hrs. Min.	8. Date of Birt (Month, Da)			place (State	or Foreign
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	p. ,		Usual Residence of Decedent 10a, State 10b, County		10c Cib	y, Town or Lo	cation						Od. Inside C	City Limits
	anyla shov	٦			100. 010									2 X No
- 1	Ne M	Director	Maryland Balt 10e. Street and Number	imore		Cocke	ysvill 10f. Zip C				10g. Citizen of	What Cour	ntry?	
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	V		30. Name and address of person & Michael Aut	NTO completed cal	7//0	ain (Item 23	sa) (Type, F	Ohio Ri	b ##	314	Bolt	mil	u 21	37		
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Amend Item 29d per dr., 6860, 10/10/06dhb. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day Year September 26, 2006 **Physician** Frances E. Farmer 1:52 PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riverview Care Center Baltimore Essex If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Funeral 1 M 2 M F Months Days Hours Director 215-24-1826 09/28/1924 West Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23e or 28a-f show other treumatic event. If a Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 Eastern Blvd. United States 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other treumatic event. If a Me Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Shahan Yula Moore ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Tedder / Nephew 1401 Redfern Avenue Baltimore, Maryland 21211 20a. Method of Disposition

1 ■ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Parkwood Cemetery 09/28/2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Service Licensee 401 S. Chester Street Baltimore, Maryland 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failere. List only one cause on each line. Arthythmias Cardianyo pothy **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificete be executed the buriei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Division of Vital Records, P.O. Box 68760, Completed by Physiclan/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To this funeral s after deau.
el Director: After th 27. Manner of Death 28a. Date of Injury (Month, Dey Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 C Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 I Homicide within 24 hours a

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completely filled Tic Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature end litle of certifier 29d. Date signed (Month, Day, Year) September 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALI KA WASELM . 709. 31. Date filed (Month, Day, 32. Registrar's Signeture State Registrar

			1 - For Amend item#	State of 7,8, perFH,	of Marylan g860, 10/1	d / Depa 12/06 Ce	artment o	of Hea	alth an eath	d Mer	ntal Hygi	ene200	6	31919
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1	1		30. Name and address of person w					.						
U	Sta	te.	MARK DAVID G 31. Date filed (Month, Day, Year)		1. D., 7 Registrar's Signa		BLER	DKI	VE T	UWS0	IN, MA	RYLAND	212	(2)4
	Registr	-		006	Sugar B		de							
		-		77		T. A.								

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

0 2006

			1 - For State Registrar	State of M	/laryland		artmen			and M		giene Reg. No.		5 3	3 9	921
п	Physici	an	1. Decedent's Name (First, Middle, Kaitlyn	Last)		6-00	zale				2. Date of Dea	Day			Time of	
	/Medio		4a. Facility Name (If not institution,	give street and number	nr)	Gon			Location o	of Death	OCTOBER		County of De		526	4 "
	Examir	ier	T. 4, 11	plaines A		1.1	Ba	11	mon	, e (1 tu		n/a	u.,,		
	Funeral		5. Social Security Number		Age on yrs. la		If Under Months		If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da NOV 1	h v. Year)	9. B	irthplace Country)	(State or	Foreign
	Director		219-73-4087 Usual Residence of Decedent	10 M 2 X F		Yrs.	10	Days 22			Nov! 1	3, 2	005 Ma	ryľa	nd	
	land ow		10a. State 10b. County		10c. City,	, Town or Lo	cation							10d. Ir	nside Cit	y Limits
	Mary Be-f eh	š	MD Balt	imore	W۲	nite M	arsh							1	Yes	2 No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What (Country?		
	a 23a		5808 Pine Hill					2116					U.S.A.			
21215-0036	i 72 hours after death with the Maryland "naturel", or Itema 23a or 28e-f ehow sidical Examinational be notified at	by Funerai	11. Marital Status 1 ⊠ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces d 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	s? ⊈No		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Original Mexican Specify:	gin? (Spe i, Puerto f	cify Yes or No Rican, etc.)		14. Race - Am Black, Wh Specify: 山	ite, etc.	idian,	
5-0	2 2 3	etec	15. Decedent's (Specify only highest			16a. Deced	dent's Usua kind of wor DO NOT us	l Occupat k done du	tion uring most	t of workin	ıg .	16b. Ki	nd of Busines	s/Industry	у	
121	.= - 20	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)		oo notus A-Chi						N/A			
d 2	Hyg Hyg Sther ant, I		17. Father's Name (First, Middle, La	ıst)					18. Mothe	r's Name	(First, Middle,	Maiden				
/lan	D 9 2 0	To Be	Darren	Gonz	alez					Kare	П		На	anna		
Maryland	d 2 sh h and 7 le m traum		19a. Informant's Name/Relationship Darren Gonzalez-				-				Route Number hite Ma			<i>Zip Code</i> 21162		
Baltimore,	Pages 1 and nent of Healt of Healt shr: If Item 2 arry or other		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Spe		_ 00	ace of Dispo metery, cren kwood	natory or of	her place			9/06		cation - City o			
Balti	permit. Pages Depertment of h Importent: If its eny injury or of		21. Signature of Funeral Service Lit	enseeWilliam	G. Da						k Towso on, MD	on Fo 21:2		Home	e, In	nc.
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	implications that cause by one cause on each	ed the death.							rest,		Inte	roximate	neev
,	Physician		Immediate Cause (Final disease or condition	a Strey.	oto coc	cal	Pre	2 nm	onia	M	eningi	2-5		7	day	
	/Medical Examiner		resulting in death)	Due to (dra	s a conseque	ence ol):			-		J				1	
4		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	is a conseque	ence of):										
V	s be executed sician end burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	is a conseque	ance of):										
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289	ificate g phy as the	9		. 0.												
O. Box	he death certificate the ettending phys ched for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown	2 Fetal of dea	death 3□	Ectopic pre Other (spe					4	23d. Date of d Month	elivery Day	Y	ear ear
P.O.	res that the disigned by the		Part II. Other significant condition	s contributing to death	but not result	ting in the ur	nderlying ca	ause giver	n in Part I.		23e. Did to	bacco u	se contribute	to the car	use of de	eath?
rds	law requires that the as been signed by th 2 should be detache	ed by									1 🗆 Y	'es 2	ZH40 3□1	robably	4 🗆 U	nknown
Vital Records,	e lawre has bea je 2 sho	Completed									24a. Was autop	an sv	24b. Were a	autopsy li	indings a	vailable use of
ᇤ	Te se	Con										med?	death? 1 ☐ Ye		No	
Zit.	ysicien: Th is certificete director, peg	Be c	25. Was case referred to medical examiner?	Hospital:				Other	-		(Check only o	-				
of	문문): To	1 ☐ Yes 2 No 27. Manner of Death	1 ≥ npat 28a. Date of In (Month, D		R/Outpatien 28b. Time of		Bc. Injury	4 🔲 Nur		e 5 Resid			ecify)		
jo	nding l ath. r: After e funer	atio	1 Natural 5 Pending 2 Accident investigat		Day Year)	Injury	м		es 2∐N	No						
=	al or Atte efter de: Directo d in by th	Certification:	3 Suicide 6 Could no 4 Homicide determine	ad 286. Place of It	njury - At hon etc. (Specify)	ne, larm, str	eet, factory	, office	<u>.</u>	2	8I. Location (S City or Tow			Rural Rou	ite Numb	ρ θ <i>Γ</i> ,
	To the Hospital or Attending within 24 hours efter death. To the Funerel Director: Attercompletely filled in by the funer	edical C	29a. Certifier (Check only one)	Physician: To the best taminer: On the basis and manner s	of examination	rledge, death on and/or inv	occurred a	at the time in my opi	, date and nion, deat	d place, a th occurre	nd due to the o	cause(s) date and	and manner a	as stated. ue to the	cause(s)	
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier				29c.	License	number			29d. Dat	e signed (Mor	nth, Day,	Year)	
			1 Gan	か			R	Es-	000			Oct	ber,	05	, 20	106
	11		30. Name and address of person wh	no completed cause of	death (Item :	23a) (Type,	Print)							-		
	M	10	31. Date filed (Month, Day, Year)	000 N 320 Regis	WOLFE strar's Signature	57	BA	MMO	RE,	MD	21	283	+			
	Sta Registr	-	QCT 1 0 2	006	WOLFE strar's Signatu	A CO	de									

Physicia /Medic Examin	a
Funeral Director	

death with the Maryland 23a or 28e-f ehow the Medical Examiner must be notified at Direct Funeral or iteme filed within 72 hours after Maryland 21215-0036 δ natural Completed Hygiene. other other treumatic event. Be **Physician** /Medical Examiner Examiner The law requires that the death certificate be executed burial-transit Box 68760, Physician/Medical thet use as ğ the page 2 should be detached o þ م ۾ Division of Vital Records, Completed hes certificete or Attending Physician: funeral director, Be Certification: To this After within 24 hours after death. To the Funerel Director: A the in by 1 filled To the Hospital Medical State Registrar

D.

ILLIAM

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. U Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) Month Da Year WILLIAM DONALD GOLDER 1200 PM OCTOBER 2006 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE CITY

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Hours | Min. | (Month, Day, Year) SINAL HOSPITAL OF BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1∏M 2□F Months Yrs. 219-38-4566 63 8-16-1943 MD Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No MD BALTIMORE WINDSOR 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21244 7101 MANILA AVENUE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 MANAGER BALTIMORE SIGN CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM GOLDER BEATRICE HOLLAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTIMORE, MD Date 20c Location - City 21244 ALICE GOLDER/WIFE 7107 MANILA AVE. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State ARBUTUS MEM. PK. 10-9-06 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tun of Funeral Service Licensee MORTON & SONS F.H. 22. Name and Address of Facility JAMES A. tortun 1701-31 LAURENS ST. BALTIMORE, MD 21217 mes Approximate Interval Between Onset and Death 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA 7 DAYS Due to (or as a consequence of): SOPHAGEAL STRICTURE 2 MONTHS Sacuratially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) C. ADVANCED STAGE NOW-SMALL CELL LUN Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an th Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide i 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe MDO 60600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO, SINAI SKARYAK HOSPITAL OF LYNNE 31. Date filed (Month Day, Year) 32. egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM 169 Der FH 9860 10/10/06 WS state of Maryland Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year £ 355 **Physician** ×ander 7001 Lobar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 18 your 5. Social Security Number 1 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 10 15 Birthplace (State or Foreign Country) **Funeral** 1√M 2□F 38 Yrs MD 10 Director 67 220-04-1668 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic event, the Medical Examinar must be notified at X☐Yes 2☐No Director NA Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 21207 U.S.A. Items 23a 7008 North Alter Street Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√☐ No If Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Lire -Salesman B.J. Wholesale 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked o Helen Shepperson ပ James Gray Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrice Gray-Wife 7008 North Alter Street, Balto, Md 21207 f Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₹ = 5 1 Burial 2 Cremation 3 Removal from State permit. Page Department of important: if sny injury or sncs. King Memorial Park 10/11/06 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licenses 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last newmonia to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been sig , page 2 should b 2 02 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No 25. Was case referred to medical examiner? VIGORIS 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director. 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification; To 2 ER/Outpatient 3 DOA this 27. Manner of Chath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 \Quadatural 5 | Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funaral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 | Homicide Hospital 1 🕽 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only fo the ! 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month)

32. Registrar's Signature

144

2006

			For State	State of Ma	ryland .		artment of H		nd Mer		2.0	106	31	0.21.
	_		Registrar Decedent's Name (First, Middle,	Last)		001	- Inicale of I	Jean		Date of Death			3. Time	of Death
	Physici /Medio		GERV CHA	RLES GR	RIFFI	N				Month ctober	Day _3, 20	Year 06	10:5	59 A ^M
	Examin		4a. Facility Name (If not institution,				4b. City, Town, or	Location of	Death		4c. County			
			Greater Baltim 5. Social Security Number		Cente		To	WSON If Under 24	4 Hrs o	Date of Birth	Balti		lass (Ctate	or Foreign
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	Aaryle st s	ō	10a. State 10b. County MD BALT	IMORE	10c. City, T		RIVER					1	0d. fnside 1 ☐ Ye	City Limits es 2⊠No
	28a-	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of V	What Cour		
	23a o	ai D	1304 WILSON	POINT ROA	D		21220					U	SA	
	r dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent of H	ispanic Origir n, Mexican, I	n? (Specify Puerto Rica	Yes or No-		e - Americ	an Indian,	
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 🕅 No tf Yes, Give Year or Dates:	0		1⊡Yes 2⊡Xvo	Specify:			Specify	WH	ITE	
9	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23a or 28a-f ahow ha Madical Examiliar mual be notified at	ted	15. Decedent's	Education	1	6a. Deced	dent's Usual Occup	ation		1	6b. Kind of Bu	usiness/Inc	dustry	
21215-0036	ithin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5-	+)	life.	kind of work done of DO NOT use retired)		- ,				
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Maryland	d be i entai ked ol	To Be	GERVIS W.	GRIFFIN					RET		alden suman ALL	10)		
ary	2 should and Men is marke aumatic	F	19a. Informant's Name/Relationshi		1	19b. Mailir	ng Address (Street a					State, Zip	Code)	
	is 1 and 2 should be filed within 72 hours after death with the Marylen of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show other traumatic svent, I're Medical Examinat must be notified at		RUTH L. GRIFF	IN/WIFE	==		4 WILSO	N POI	NT R	DAD BA	ALTIMO	ORE,	MD :	21220
ore	Pages 1 nent of H int: If Itse		20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3	3 □Removal from State	ceme	etery, crer	sition (Name of natory or other plac		Date		0c. Location -	•		
altimore,	permit. Pages Depertment of Importent: If It eny injury or o		4 □ Donation 5 □ Other (Special Signature of Funeral Service Li	7	METI	1	REMATOR: Name and Addres		0/4/0		BALTIN			
Ba	Dep Impo		100				211 CHE		AVEN	CH/ROS JE BAI	TO.,	MD .	NERA 2123	ь ном. 7
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused to only one cause on each line	the death. [Do not ent	er the mode of dyin	g, such as ca	ardiac or res	spiratory arres	st.		Approximation Interval Bio	etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- a. Pulmona	14	hyp	letenses	<i>.</i>				(MON	
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9	tificate ig phy as the	edic		0.								-		
Вох	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	of pregnancy 2 Feter dea		Ectopic pregnancy					e of delive	. ,	W
	The law requires that the death certificate been signed by the attending of age 2 should be detached for use as	Physician/Me	1 Tyes 2 No 9 Unknown	4☐ Pregnant at t 9☐ Unknown	ime of death	1 5□	Other (specify)				Mo	nta	Day	Year
α.	res that the digned by the be detached	y Ph	Part II. Other significant condition	s contributing to death but	t not resultin	g in the ur	nderlying cause give	en in Part I.		23e. Did toba	icco use conti	ribute to th	e cause of	death?
rds	w requires been sign should be	ed b	Biventricular	most to	ilure				_	1 🗆 Yes	2 No	3 🗆 Prob	abiy 4	Unknown
Records,	hes be	Completed by	Kenal insuffici	ency progres	sing t	o re	nal faily	ve.	_	24a. Was an autopsy	24b. \	Were auto	psy finding	s available
			Marbid obser	ty O'	U					perform	ed? c	leath?		
Viital	Phyeician: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			• all poal Othe		,	eck only one				
0	는 는 등	n: To	27. Manner of Death	28a. Date of Injury (Month, Day		Outpatien b. Time of	I SU DOA	4 LI Nursi		5 Residen			()	
Sior	Attendin death. ctor: All y the fur	atio	1 Natural 5 Pending 2 Accident investiga	tion	rear,	Injury		r res 2 □No	•					
Division	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At home, . (Specify)	, farm, str	eet, factory, office		28f.	Location (Stre City or Town,	et and Numb State)	er or Rura	l Route Nu	mber,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a Certifier 1 Certifying (Check only 2 ☐ Medical E)	Physician: To the best of caminer: On the basis of c	t my knawlac	dge death	occurred at the time	e date and a	place, and o	Stra to the eau	es(s) and ma	nner as st	ated.	(a)
	thin 24 thin 24 the F	Medical	one) 29b. Signature and title of certifier	and manner state	ed.		29c. License				d. Date signed			
)	F 3 F 8		Marie Page	-			0209				0/3/0		-u _j , (cai)	
1	. *		30. Name and address of person w	no completed cause of de	ath (Item 23	a) (Type,					, -10	Ø	TV.	
4			31. Date filed (Month, Day, Year)	tha m		BUC	Huspital	, Be	Hin	1101.	Md_	212	04	
	Sta Registr		OCT 1 0	2006 32. Registrar	s Signature	,	034/2							
		-		100000	and the state of t	100	Andrew Charles			_				

ORIGINAL

		-	For State Registrar	State of N	Maryla		artment of H		Mental Hygid	ene 3. No. 2006	31925
	Physicia		Decedent's Name (First, Midd CTAI	lle, Last) NLEY	м.		INSBURG		2. Date of Death Month OCTOBER	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution					Location of Death		4c. County of Dea	6:40 A M
	LXammi	C.	HOSPICE OF BAL	TIMORE GILCH	IRIST	CTR.		TOWSON			TIMORE
	Funeral Director		5. Social Security Number 028-34-5961	6. Sex 1	Age (In yrs 59	s. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 04/24/19	rear) C	rthplace (State or Foreign ountry) MASS
	and w		Usual Residence of Decedent 10a. State 10b. Count	у	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	Maryl	ţō	MD	HOWARD		LAUR	EL				1 ☐ Yes 2 ☐ No
	or 284	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What C	•
	eath w	Funeral	9457 FENS HOL	_LOW 12. Was Decede	nt Ever in	U.S. 13	Was Decedent of H	20723	pecify Yes or No-	14. Race - Am	USA erican Indian,
036	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", or Items 23a or 28a-f ehow appringuty or other treumatic event, in Medical Examinar must be notified at 2006.	þ	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 🛣 Divorce	rried 1 Yes 2	s? No		lf Yes, specify Cuba 1 □ Yes 2 X No	n, Mexican, Puert	o Rican, etc.)	Black, Wh	ite, etc. WHITE
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	Pnysician /Medical		disease or condition resulting in death)	aDue to (or	s a conse	equence of):	drone in syn				wys
	Examiner		Sequentially list conditions	D			on syn	done			works
W	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conse	equence of):					
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Box 6	Attending Physicien: The law requires thet the death certific: r death. ector: After this certificate hes been signed by the attending pl by the funeral director, page 2 should be detached for use as it	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth	n 2 □ Fe tat time of	tel death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of d Month	elivery Day Year
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296. Signature and title of certifier Colcultation O.C.M.E. October 4, 2006 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	587 ertifice ding p	as th		3b. Was decedent pregnant in th	Live		- 44-		3 Ectop	ic pregnar	псу		Month	Day	Year	
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24 Date filed (Month) Day Your) 32 Remotrar's Signature				Colyer	and	5,		Ο.	C.M.E.			Oc	tober 4, 20)06		
24 Date filed (Month) Day Your 132 Registrar's Signature 132 Registrar's Signature 133 Registrar's Signature 134 Page 135 Page 136 Page 136 Page 136 Page 137 Page 138 Page 13	2		ŀ								204					\neg
State 31. Date filed (Month) Day Year) 0 2006 32. Registrar's Signature						AL .		nn Street, B	altimore,	MD 212	201					
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			For State Registrar	State of Man		artment of H			ene g. N2 0 0 6	31927
			Hegistrar Decedent's Name (First, Middle, La	st)		timouto or L	30417	2. Date of Death	1	3. Time of Death
	Physicia /Medic			Philip Ha	arley			October	Day 2006	6:00 A M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	h
			$337\frac{1}{2}$ Gorman Ave			Laurel			Prince G	
П	Funeral		5. Social Security Number 6. S	ex 7. Age (/ Ճм 2□F 56	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 1,	Year) 9. Bin 1950 SQU	hplace (State or Foreign untry) th Carolina
	Director		251-88-4428 Usual Residence of Decedent	1 30				Bept 1,	1930 304	cii carorriia
	nyland how		10a. State 10b. County	10	0c. City, Town or Lo	ocation				10d. Inside City Limits
	86-1-8	Director	MD Prince	George 1	Laurel					1 X Yes 2 □ No
	with the	Dire	10e. Street and Number			10f. Zip Code			g, Citizen of What Co	untry?
	ns 23	erai	337½ Gorman Ave	nue 12. Was Decedent Eve	er in U.S. 13.	20707 Was Decedent of Hi	ispanic Origin? (Sp		J.S.A. 14. Race - Ame	ncan Indian,
(0	r Iten	by Funeral	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	1	Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	Black, Whit	e, etc.
9	hours after death with the Maryland turat; or Items 23a or 28e-1 show at Evandret must be notified at	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 19	972-75	1□Yes 2፟MiNo	Specify:		Specify: Bla	ick
<u>2</u> -0	natu	Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ring 1	6b. Kind of Business	Industry
2	within ene. then	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		enter	9		Construct	ion
0 0	filled Hygid Sther ent.	e Co	17. Father's Name (First, Middle, Last)	Calp	enter	18. Mother's Nam	e (First, Middle, M		1011
an	lid be lental ked c	To Be	Kissler David H	arley, Sr.			Allene M	Moody		
Maryland 21215-0036	shou and M s mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a	and Number or Rur	al Route Number,	City or Town, State, 2	Zip Code)
Σ.	and 2 salth n 27 l		Patricia Harley							icut 06469
altimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑	1	20b. Place of Dispo cemetery, crea	osition (Name of matory or other plac		Date 2	0c. Location · City or	Town, State
Ē	Pag tment tent: jury c		* 4 ☐ Donation 5 ☐ Other (Speci	(y)		s Cemete	the state of the s			th Carolina
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. I filmportent: If I fem 27 is marked other then "natural", or items 23a or 28e-1 show any injury or other treumatic event, the Medical Evantrue must be notified at once.		21. Signature of Funeral Services Lice			2. Name and Addres Onaldson 13 Talbot			A. aryland 20	707-4389
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Hiysician -		Immediate Cause (Final disease or condition		ell lung	cancer				Onset and Death 1 year
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):					
	LAGITIMICI	_	Sequentially list conditions,	b. — Due to (or as a c	consequence of)-					
Ve	ned nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury	233 (3) (3) 43 43						
,	te be executed ysician and ie burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a c	consequence of):					
,092	m > 0	cai		_ d						
89	artifica ing ph e as th	Med	IF FEMALE:							
Вох	death certifica e attending ph od for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
o.	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at tin 9⊡ Unknown	ne or death 5 E	Other (specify)			1	
۳.	The law requires that the de ate has been signed by the page 2 should be detached	y Ph	Part II. Other significant conditions	contributing to death but r	not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds	quires n sign	ed by						1 💢 Yes	s 2 No 3 P	obably 4 Unknown
Records,	s bee	Completed						24a. Was an	24b. Were at	utopsy findings available completion of cause of
Ä	The tav	mo						autopsy perform 1 ☐ Yes 2	ed? death?	
Division of Vital	sician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					h (Check only one	7)	
<u></u>	this all div	၉	1 ☐ Yes 2XXNo	Hospital: 1 Inpatient					nce 6 Other (Spe	cify)
חכ	ing Afte une	lon	27. Manner of Death 1XXNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	Worl	/at k? Yes 2 □ No	28d. Describe how	w injury occurred	
18	ten leat tor: the	ficat	2 Accident investigation 3 Suicide 6 Could not to determine	B Con Class of Injury	- At home, farm, st		103 2 110	28f. Location (Str.	eet and Number or R	ural Route Number,
<u>></u>	after after Dire d in b	Certification:	4 Homicide determination	building, etc. ((Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical C		nysician: To the best of r	xamination and/or in					
	o the ithin 2 o the omple	Mec	29b. Signature and title of certifier	and manner state	u.	29c, License	a number	29	d. Date signed (Mon	h, Day, Year)
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,	140		30. Name and address of person who		th (Item 23a) (Type, Van Duse	Print)			, Maryland	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's		in Road E	74100 220	Taurer,	, mary rand	20101
	Registr	ar	OCT 1 0 2	UU6 Page	18 4	carles				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienes 31928 Reg. No. Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** A^{M} Elsie Anita Hertz October 6, 2006 4:30 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George Laurel Mariner Health of Greater Laurel 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 1918 Maryland Director 212-30-2827 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County worle rthen "natural", or Itams 23a or 28a-f ehov tre Medical Examiner must be notified at 1√ Yes 2 No Director Prince George Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20707 U.S.A. 14200 Laurel Park Drive death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Colombian Baltimore, Maryland 21215-0036 Specify: White 1X Yes 2□ No 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy. Important: if item 27 is marked othe eny injury or other traumatic event, odgs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown Bernardine Robert Forero 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 151 Farm Pond Lane, Martinsburg, WV 25404 Michael Hertz 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Arundel Crematory | Oct 7, 06 Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio Vascular tranio scendtic OVOS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): sicien a burial-Division of Vital Records, P.O. Box 68760. Physician/Medical phys as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No
9 Unknown Month Day ò 4 Pregnant at time of death 5 Other (specify) 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy page performed? 1 Yes 1 🗌 Yes 213-No 2 3 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2006 D0024721 M.X

State Registrar

3

31. Date filed (Month, Day, Year) n 2006

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED SADO 14333 Laurel Bruie

Read

St 208, LAUREL MY 20708

			1 _ State		partment of Health and ertificate of Death		ZUUb	31929
			Registrar 1. Decedent's Name (First, Middle, Last)		A. I	2. Date of Death		3. Time of Death
	Physici /Medic		ALMETTER	3	HUNTER	October	6 2006	200PM
	Examin		4a. Facility Name (If not institution, give si	reet and number) Sing Home Hicker 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs	8. Date of Birth	4c. County of Death 9. Birthpl	lace (State or Foreign
	Funeral Director		246-64-1016 10	M 201 / 00 Yrs.	Months Days Hours Min.	SEPT, 15,	1906 NOR	TH CAROLINA
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location	/	11	0d. Inside City Limits
	a-f sh	to	MARILAND NI	A	BALTIMO	RE CIT	7/	1 XYes 2 □ No
	or 28	Director	10e. Street and Number	1 00 15	10f. Zip Code	10g. (Citizen of What Coun	try?
	eath v	Funeral	4 8 00 SETOR	2. Was Decedent Ever in U.S. 1:	3. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Americ	an Indian,
21215-0036	hours after death with the Maryland turel', or Items 23e or 28e-f show al Examinational be notified at	ρ	1 Never Married 2 Married 3 🖾 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puèr 1 ☐ Yes 2 (X) No Specify:	to Rican, etc.)	Black, White, Specify: BL	ACK
15-0	22 8 3	letec	15. Decedent's Educ (Specify only highest grade	completed) (Gi	cedent's Usual Occupation ve kind of work done during most of wo b. DO NOT use retired)		. Kind of Business/Inc	dustry
212		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		RKER C	LEANING	SERVICES
	be filed ntal Hygi od other event, L	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Maid	den Surname)	
Maryland	Mer	၉	GEORGE 19a. Informant's Name/Relationship (Type		ES KEN	ural Route Number, Cit		NES Code)
Ma			DOROTHY BROWN	(DAUGHTER) 30	07 OAKHILL AV	E. BAL	TO, MO.	21207
ore,	ges 1 an it of Heal if item 2 or other		20a. Method of Disposition 1 Burial 2 Cremation 3 □ Re	20b. Place of Dis	position (Name of rematory or other place)	Date 20c.	Location - City or To	wn, State
Baltimore	Pa ant: ury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	WOOD	LAWN (EME. 10 - 22. Name and Address of Facility 2)	16-06 W	OODLAW.	N. MD.
Ba	permit. Departr Importu eny inji		21. Signature of Pulleral Service License	N. Williams	T -/ 1/ 0 T	Page 1 / /	ne Baltin	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	eations that caused the death. Do not de cause on each line.				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Atherosch	erotic Cardie	Vascular	- Disea	
	Examiner			Due to (or as a consequence of):	Astory D	seese		
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
	and and II-trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):		··- · · · · · · · · · · · · · · · · · ·		
8760	icate be executed physicien and s the burial-transit	dical E	€ d					
9	entifica ling ph e as th	Medi	IF FEMALE:					
.O. Box	st the death certific by the attending p tached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	nry Day Year
Vital Records, P.	signed be de	þ	Part II. Other significant conditions con	tributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	1 /
ecc	e law requ hes been je 2 shoul	Completed				24a. Was an autopsy performed	prior to cor	psy findings available inpletion of cause of
alF		e Cor	25. Was case referred to medical		OC Please of Do	1 ☐ Yes 2 ☐		2 □₩
Z	S D	To B	evaminer?	ospital: 1 □ Inpatient 2 □ ER/Outpa		Home 5 Residence	6 ☐Other (Specify	y)
sion of			27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injur		28d. Describe how in	njury occurred	
Division	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	d Route Number,
	Hospit 24 hour Funer etely fills	Medical			eath occurred at the time, date and place r investigation, in my opinion, death occ			
	To the within To the comple	Me	29b. Signature and title of certifier	0	29c. License number	29d.	Date signed (Month,	Day, Year)
)			1 west	γ n	0. 104/40	10	19100	
)		30. Name and address of person who co	mpleted cause of death (Item 23a) (Tyl	ENTEW ST.	Baltimo	MM).	2/20/
	Sta Regist		31. Date filed (Month, Day, Year) OCT 1 0 200	32. Hegistrar's Signature	porte			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien® 0.0.6

			1 - State Registrar		State of Ma		Certifica				ene UU6	31930
	Physici	an	Decedent's Name (First) Lillian	, Middle, Las	v R.	ī	Hamilto	n		2. Date of Death Month October		3. Time of Death 10:45 AM
	/Medic Examin		4a. Facility Name (If not ins	stitution, give					r Location of Death		4c. County of Dea	
			77 Ginwood L	ane				Essex			Baltimo	
	Funeral Director		5. Social Security Number 218–36–0183		ox 7. Age □M 2【X】F	(In yrs. last bir	Yrs. If Unit Month	der 1 Year Is Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, February	9. Bir 21, 1940 MA	thplace (State or Foreign ountry) ryland
	yland now		Usual Residence of Deced 10a, State 10b. 0	County		10c. City, Tow	n or Location					10d. Inside City Limits
	Ba-f et	ctor	_	ltimor	e	Es	ssex					1 ☐ Yes 2 📉 No
	swith the	i Dire	10e. Street and Number 77 Ginwood L	ane			10f.	Zip Code 2122	1	10	0g. Citizen of What Co USA	ountry?
036	be filed within 72 hours after death with the Maryland is I Hygiene. A other than "natural", or iteme 23a or 28a-f show of ther than "natural", or iteme 400 or 28a-f show event. The Medical Examinat must be notilised at	by Funeral Director	11. Marital Status 1 Never Married 2[3 Widowed 4 Di		12. Was Decedent E Amed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates;				lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit Specify: Whi	te, etc.
Maryland 21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. De (Specify only Elementary/Secondary (ucation de completed) College (1-4or 5-	16a.	Decedent's U (Give kind of life. DO NO?	sual Occup work done use retired	ation during most of won d)	king	16b. Kind of Business	/Industry
7	filed wit Hygiene Sther the		12 years			,	Floral	Desi			Florist	
and	D E 2 0	To Be	17. Father's Name (First, Magnetic Jefferson Cu						Helen I	ne (First, Middle, N Moore	Maiden Sumame)	
a _Z	d 2 should the and Ment it is marked treumatics	ř	19a. Informant's Name/Re		• • • • • • • • • • • • • • • • • • • •		•		and Number or Ru	ral Route Number,	City or Town, State,	
	is 1 and 2 of Health item 27 i		Donna Beres		Daughter				Road, Di			1222
Baitimore,	permit. Pages 1 Department of H Important: If ite eny injury or ot		20a. Method of Disposition 1 X Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ O	nation 3 🗌			Disposition (I ry, crematory of awn Cem	etery	11,	2006 I	20c. Location - City or Dundalk, Mai	ryland
ng Pa	permit. Depart Import eny inj		21. Signature of Furieral S	Service Licen	see		Conne 7110	and Addre	ss of Facility Tuneral Ho ers Point	ome Of Du Road, Du	ındalk,P.A ındalk,MD.	21222
	Physician		Immediate Cause (Final	ase, or comp e. List only	olications that caused one cause on each lin	Θ.	not enter the m	ode of dyin	ig, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		a	consequence	of):					
Ī	Examiner	iner	Sequentially list conditions if any, leading to immedial cause. Enter Underlying Cause (Diseese or injury	ie d	b. Due to (or as a	consequence	of):			······································		
₽,09/89	lificate be executed g physicien and as the burial-transit	cal Examiner	that initiated events resulting in death) Last	l	Due to (or as a	consequence	of):			-		
	rtificat g phy as the	Aedicai	15.55441.5		0.							
.c. Box	that the death certific ed by the attending p detached for use as	ysician/M	IF FEMALE: 23b. Was decedent pregn in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	arii	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopio 5 □ Other				23d. Date of de Month	livery Day Year
7	The law requires that to the has been signed by age 2 should be detailed.	d by Physi	Part II. Other significant of	onditions co	ontributing to death bu	t not resulting in	n the underlyin	g cause giv	en in Part I.		pacco use contribute to	o the cause of death?
ecords,	w requ	etec								24a. Was ar		utopsy findings available completion of cause of
r		Completed								autops perform	ned? death?	completion of cause of 2 □ No
VITAI	icien: certific ector,	a	25. Was case referred to rexaminer?	medical	Hospital:			Oth		th (Check only on		
5	Phys	٦. ا	1 Yes 2 No		28a. Date of Injur		Time of	DOA 28c. Injur		ome 5 Peside 28d. Describe ho	nce 6 Other (Spe	ecify)
lo l	ath. rr: Afte	atlor	1 ☑Natural 5 ☐ 2 ☐ Accident	Pending investigation	(Month, Day	Year) I	njury M	Wor	k? Yes 2 □ No			
DIVISION	el or Atte s after de al Directo ed in by th	Certification:	3 Suicide 6 S 4 Homicide	Could not be determined	28e. Place of Inju building, etc	ry - At home, fa . (Specify)	rm, street, fact	tory, office		28f. Location (Sti City or Town	reet and Number or R n, State)	u <i>ral R</i> oute Number,
	To the Hospitel or Attending Physicien: within 24 hours after deals after deals To the Funerel Director: After this certifica completely filled in by the funeral director;	edical (29a. Certifier 1 ☑ C (Check only 2 ☐ M	ertifying Ph edical Exam	ysician: To the best on niner: On the basis of and manner sta	examination an	e, death occurr d/or investigat	ed at the tir	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To th withir To th comp	M	29b. Signature and title of	certifier	~ M	Λ		29c. Licens		29	9d. Date signed (Mon	
			, 6	0				DS	064624		10/10/20	C 6
	12		30. Name and address of p	wood				0	21561			
	Sta	te	31. Date filed (Month, Day	Year)	32. Régistra	r's Signature	Local	<i>y</i> ,				

		•	For State Registrar	State of Maryland		epartment of Healt Certificate of Dea		tal Hygien Reg. N	21116	31931
	Physici /Medic	3.0	1. Scedent's Name (First, Middle, Last	nsen			2.0	Date of Death	8 2 Year	3. Time of Death
	Examin Funeral Director		5. Social Security Number 6. Security Number 218-14-5014	street and number)			nder 24 Hrs. 8. Curs Min.	Date of Birth Month, Day, Yea ec. 19, 19	r) Co	th YE thiplace (State or Foreign country)
	land W		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town	or Location				10d. Inside City Limits
	Mary me-f mh	ģ	Maryland Baltimor	e Cat	ton	sville				1 ☐ Yes 2 ☑ No
	or 28	Directo	10e. Street and Number	***		10f. Zip Code		10g. C	itizen of What Co	ountry?
	eath w		426 Westside Blvd	12. Was Decedent Ever in U.S.		21228	o Origin? (Specify		SA 14. Race - Ame	nican Indian
036	urs after de al', or Itam Examiran	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII	•	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 □ Yes 2 ☒ No Specify		n, etc.)	Black, Whit	
21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or itams 23s or 28s-f show imatic event, the Madical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	le completed) College (1-4or 5+)	16a.	Decedent's Usual Occupation (Give kind of work done during life, DO NOT use retired)	most of working	16b.	Kind of Business	
22	Hygier thar ti		17. Father's Name (First, Middle, Last)	2		Homemaker 18. M	Nother's Name (Fir	st, Middle, Maide	Own Hor	ne
Maryland		To Be	Jerome Emge				Claire		,	
ary	shou and M s mar		19a. Informant's Name/Relationship (T)	vpe, Print)	19b.	Mailing Address (Street and Nu	umber or Rural Ro	ute Number, City	or Town, State,	Zip Code)
	and 2 ealth a m 27 i		Cheryl Wasmund	Daughter		Osborne Avenue				
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Itam 27 is marked any Injury or other traumatic av <u>snca</u> .		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	netery	Disposition (Name of v, crematory or other place) SVII1e	Date 10/12/2	006 Cr	ocation - City or	e, MD
Ball	Depart Import any In		21. Signature of Juneral Service License	Delwake	3	22. Name and Address of F. Funeral Hom 1630 Edmond	e of Cat son Aven	ng Asnic onsville ue; Cato	n Schwa , Inc. nsville	MD 21228
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. ne cause on each line.	Do n	ot enter the mode of dying, such	h as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aS	E	PSIS				
	Examiner			Due to (or as a conseque	ence o	τ):				
	7 -	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	nce o	f):				
B	ecuted and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseque		41.				
68760,	ificate be executed g physicien and as the burial-transit	edicai E		d	1100	.,.				
_	sertifica ding ph se as th		IF FEMALE:	23c. If yes, outcome of pregnance	CV				004 0-464-	
P.O. Box	res that the death certifigned by the attending be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	Day Year
	quires that n signed b uld be deta	ρ	Part II. Other significant conditions co	ntributing to death but not result	_		Part I.	23e. Did tobacco		o the cause of death?
Division of Vital Records,	Attanding Physician: The law requires that the death certifudath. It death. metor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a by the funeral director, page 2 should be detached for use a	Completed						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Ita	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				Place of Death (Ch			
5	Physic this c	မှု	1 ☐ Yes 2 ☐ No 27. Mann of Death	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Out		Nursing Home	5 Residence		cify)
0	th. : After tuner	tion	Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		ime of 28c. Injury at 32c. Mork? M 1 ☐ Yes 2		Describe now in	ary occurred	
Divisi	or Attan efter dea Diractor Jin by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, far	m, street, factory, office		ocation (Street a City or Town, Sta		ural Route Number,
	To the Hospital or Attending Physicien: The within 24 hours efter death. To the Funeral Director: After this certificate h. completely filled in by the funeral director, page	Medical C	29a. Certifier Check only one) Certifying Phy 2 Medical Exam	sician: To the best of my know iner: On the basis of examination and manner stated.	ledge,	death occurred at the time, dat for investigation, in my opinion,	te and place, and o	due to the cause(the time, date a	s) and manner a nd place, and due	s stated. e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	1		29c. License numb	ber	29d. D	ate signed (Mont	h, Day, Year)
			Vasueen	Valla	n	D384	75	1	0/10/07	5
_	181		29b. Signature and title of certifier Jacuary 30. Name and address of person why companies of person who companies the second of the second	ompleted cause of death (Item 2	23a) (Type, Print) PARK H	Kel GHITS	AVE	BAG	JUSTE (IM UT
	Sta Registi	te ar	OCT 1 0 2006	A. Hegistrar's Signatu	ILO	1004				

			1 - For Amend Item Registrar	29d State	of Maryla Dr G86		artment of H / 06dhb <i>tificate of i</i>	lealth and Death	l Mental Hyg	giene Reg. 2 0	06	31932
and All	Physici	20	Decedent's Name (First, Midd	dle, Last)					2. Date of Dea Month		Year	3. Time of Death
	/Medic		Oliver Horto						May 16,	T		11:31 A M
*	Examin	er	4a. Facility Name (If not institution				4b. City, Town, or		ath	4c. Coun	ty of Death	1
- Ar-			Ravenwood Nu			a face block it. I	Balti If Under 1 Year	MOTE If Under 24 H	re a Data (Dia		0.001	1 (0
	Funeral		5. Social Security Number	6. Sex 1√2 M 2 ☐ F		s. last birthday) Yrs.	Months Days	Hours Mi		7. Year) 1030	9. Birti	nplace (State or Foreign untry) Unknown
A STATE OF	Director		018-30-7626 Usual Residence of Decedent	12	67				May 3,	1939		OHMHOWH
	/land		10a. State 10b. Count	у	10c. 0	City, Town or Lo	cation					10d. Inside City Limits
	Man fied	į	MD			Baltimo:	re					M∑Yes 2 No
	r 28g	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Co	untry?
	23a o	a D	501 W. Frankli	in Street			21201			USA		
	deal	Funeral	11. Marital Status Unk.	12. Was De Armed F	cedent Ever in	U.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No-	14. Ra	ice - Amei ack, White	ncan Indian,
9	or Ite		1 Never Married 2 Ma		2 □ No Th	nlr		Specify:	one mean, etc.,			
8	ural',	d by	3 Widowed 4 Divorce	d Year or	Dates:		1 ☐ Yes 2 ☐ No X				ity: wh:	
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12	Mithir Shen		Elementary/Secondary (0-12)		(1-4or 5+)		DO NOT use retired	")		I balesa	OT 700	
2	be filed within 72 hours after death with the Maryland at Hygiene. d ot Hygiene. d other than "natural", or items 23a or 28a-f show event. I.e Medical Evacili at round be notified at		Unknown 17. Father's Name (First, Middle	Unknowr	1	Unic	nown	18. Mother's N	ame (First, Middle,	Unkn Maiden Suma		
an	d be antal	9 Be	Unknown	,,				Unkno				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentle Hygiene. Department of Health and Mentle Hygiene. The mortant: If the 27 is marked other than "natural; or tiems 23a or 28a-f show any injury or other traumatic event. The Medical Examinational Languages. PAGES.	ပ	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	na Address (Street)		Rural Route Numbe	r. City or Tow	n. State. Z	ip Code)
S	ith ar ith ar 27 ts trau		11				•		et, Baltin			
ā,	Hea Hea tam othar		20a. Method of Disposition	aing none	20b.	. Place of Dispo	sition (Name of		Date	20c. Location		
Baltimore,	ages ant of it: ff I		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 □Removal from	n State	cemetery, crei	natory or other plac	:e)				
	artme ortan injur		21. Siz Jura f Funeral Service		ate	22	2. Name and Addres	ss of Facility				
ä	per den eny			Waden Dire	ectcr				Soard, 655	W. Ba	lto.	St.,
	150		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	caused the de	ath. Do not ent	Baltimor er the mode of dym	g, such as card	ACOT lac or respiratory ar	rest,		Approximate
	Dhysisian		Immediate Cause (Final									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	quired of (or as a conse		Deficienc	y synar	One			Years
	Examiner		voir I London de California de		(0) 40 4 001101	04201100 01).						
	4.	Jer	if any, leading to immediate	Due to	o (or as a conse	equence of):					- 17	
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	•								
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Вох	The law requires that the death certify is the law requires that been signed by the ettending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		utcome of preg birth 2 ☐ Fe		Ectopic pregnancy				ate of deli Ionth	very Day Year
o.	e des the ett	SICI	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□ Unk	nant at time of nown	death 5	Other (specify)				ionar	Day 164
<u>Ч</u>	d by t	Phy			d			1. B. Al	OO- Did As			share and all as the 2
Ś	res th signer	ρ	Part II. Other significant condit	ions contributing to	death but not re	esulting in the u	nderlying cause givi	en in Paπ I.		_		the cause of death?
0	w require been si should	eted			· · · · · · · · · · · · · · · · · · ·					es §x⊡No	30110	Dably 4 Donkhown
Vital Records,	slaw bash 62s	Completed							24a. Was autop	sy	prior to d	topsy findings available ompletion of cause of
		õ							1 ☐ Yes	med? ≱□ No	death? 1 ☐ Yes	.2.□ No
/its	ician Sertifii Botor	Be	25. Was case referred to medic examiner?				i Out		eath Check only o	ne)		
of	Phys this aldi	၉	1 Yes 2 No			ER/Outpatier		4 Nursing	Home 5 Resid			ify)
Ľ.	ding I	o	27. Manner of Death 1 □ Natural 5 □ Pend	ing (Mo	e of Injury nth, Day Year)	28b. Time of Injury	Worl	k?	28d. Describe h	low injury occu	itted	
Sic	death death ston: the t	icat	3 ☐ Suicide 6 ☐ Could	not be	f laine - At	hama fare at		Yes 2□No	29f Lagation /6	Strong and Advan	has as Co	and Charles Museuman
Division	I or Atter after death Director:	Certification:	4 Homicide deter		ding, etc. (Spec		eet, factory, office		City or Tow		iber or Au	ral Route Number,
	spital ours seral filled		29a. Certifier 1☐ Certify	ing Physician: To the	ne heet of my ki	nowledge death	occurred at the tim	ne date and nia	ce, and due to the	Pause(s) and n	2200001 36	ctated
	To the Hospital or Atter ding within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely filled in by the funer	edical	(Check only 2 Medica	ing Physician: To the I Examiner: On the and ma	basis of exami nner stated.	nation and/or in	vestigation, in my o	pinion, death oc	curred at the time,	date and place	, and due	to the cause(s)
	To the within 2 To the complet	₩	29b. Signature and title of certifi	A	1		29c. License	e number		29d. Date sign	ed (Month	, Day, Year)
	- > P 0		→ A	Xara	U_		D070	".O	.1	fune 28	200	06
			30. Name and address of person	whe completed car	use of death (Ite	em 23a) (Type	D2192	40			,	
			Leonel Barahon					t City	MD 21042			
	Sta	te	31. Date filed (Month, Day, Year	r) 32.	Registrar's Sig		and the desire C.C.					
	Registr	ar	OCT 1 0 20	U6	1	A						

ORIGINAL

DHMH 17 Rev 1/2001

			1 - For State Registrer	State of I	Maryland	d / Depa <i>Cei</i>	artment tificate	of He	alth a leath	nd Me	ental Hy	giene	2006	31	933
	Physici	an	1. Decedent's Name (First, Middle,		ARRIS	•					2. Date of De Month	Day	1 200 E		ol Death 22 P M
	/Media	cal	4a. Facility Name (If not institution,	1			4b. City, To	wn. or L	ocation of	Death	och!		County of Death		ZZ 1 M
1	Examir	ier	Howard Co. Ge					Lumb					Howard		
	Funeral				Age (In yrs. la		If Under 1		If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da	th sy, Year)	9. Birth Cor	place (Stati	e or Foreign
	Director		246-18-1512 Usual Residence of Decedent	1 4 M 20F	8:	5 Yrs.						20-19			1.C.
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside	City Limits
	• Man	ţċ	Md. Balti	lmore		Ca	tonsv	ille						¹ 火 Y	es 2 No
	or 28	Director	10e. Street and Number			-	10f. Zip C	ode				10g. Citiz	en of What Cor	intry?	
	a 23a	rai	1207 Pleasant					1228					SA		
	itsm itsm	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decede Armed Force ed 1 \(\text{Yes} 2 \)	s?	i. 13. \	Vas Deceder f Yes, specify	t of Hisp Cuban,	Mexican,	Puerto R	ofy Yes or No lican, etc.))- 1	 Race - Amer Black, White 		
99	er's el	b	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Date	••		I□Yes 25	No	Specify:				Specify: Bl	ack	
21215-0036	ilied within 72 hours eiter deeth with the Maryland Hygiene. Ither then "natural", or itams 23a or 28e-f show Int., the Mudical Examinar riust be nutified at	Completed by	15. Decedent' (Specify only highest			(Give	lent's Usual (kind of work	done dui		of workin	q	16b. Kir	nd of Business/I	ndustry	
121	within ne. then	ig i	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. I	DO NOT USB Nitatio	retired)	•		-	Bal	timore	City	
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Maryland	ges 1 end 2 should be fited withir t of Health and Mental Hygiene. If item 27 is marked other then or other traumatic svent, Ins M.	To Be	Joe		Har	ris			Pear	clie			Lynch		
lary	2 should and Men is marke surnation	-	19a. Informant's Name/Relationsh	nip (Type, Print)			-					-	Town, State, Z		01000
	of Health Hem 27		Joann McGriff 20a. Method of Disposition		20h Pla)'/ PIea sition (Name	_	t Val		Dr., (sville,		21228
Baltimore,	nt of h		1 ☑ Burial 2 ☐ Cremation			metery, cren	natory or othe	er place)	1				cation - City or 1		
Ë	permit. Pag Depertment Important: ii any injury o		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L	•	Ki	ng Men	. Pk.	Address		0-7-			ndallst	own, !	id.
B	permit. Depertre Importa any inje		13 MMa				101 E	. No	rth A		March Balti			21202	
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caus	n line.	Do not ent	er the mode	ol dying,	such as c	ardiac or	respiratory a	rrest,		Approxim	etween
1	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	Athe	roscle	rolic	Co	ardi	ovas	Cula	v D	Iscare	Onset an	d Death
	/Medical Examiner		resulting in deathy	Due to (or	as a conseque	ence ol):									
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90,	cate be executed obysicien and the burial-transit		resulting in death) Last	Due to (or	as a conseque	ence of):									
8760,	physic physic the b	dica		d											
Box 6	eath certific attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor								2	3d. Date ol deli	/өгу	
B.	death ne atte ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetel of dea]Ectopic preg] Other <i>(spec</i>						Month	Day	Year
P.0	that the de ned by the a deteched	Phy	9 ☐ Unknown Part II. Other significant condition			tion in the u	- dorbing cou		in Bort I		22a Did	lobagoo u	se contribute to	the cause o	f dooth?
ds,	es ped	d by	ran ii. Ottor significant conductor	113 CONTIDUCING TO GOAL	i but not resur	ung in the di	idenying cad	se giveri	airaiti.			Yes 2			⊈Únknown
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Be	The lay	ошь									auto		prior to c death? 1 ☐ Yes	ompletion o 2□ No	cause of
ita		Bec	25. Was case referred to medical examiner?					2	26. Place	of Death	(Check only	/		20,10	
<u>ک</u>	> .e ₽	၉	1 ☐ Yes 2 XNo	Hospital:		R/Outpatien		Other:	4 🔲 1901				Other (Spec	ify)	
	ding After fune	tlon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	9	Day Year)	28b. Time of Injury	M 280	. Injury a Work?	ıt əs 2.⊟N		Bd. Describe	how injury	occurred		
Division	i or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of									Number or Ru	ral Route N	umber,
ā	5 th 6	Certification;	4 Homicide	building,	etc. (Specify)					į	City or 10	wn, State)			
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical E	g Physician: To the be Examiner: On the basis	of examination	rledge, death on and/or inv	occurred at estigation, in	the time, my opin	, date and nion, death	place, an	nd due to the d at the time,	cause(s)	and manner as place, and due	stated. to the cause	a(s)
	o the ithin 2 o the omple	Med	one) 29b. Signature and title of certifier	and manner			29c. l	icense r	number			29d. Date	signed (Month	Day, Year)
	- s + o		> 500 a	Sun			$ \mathcal{D} $	30	641			octo	ver 2	200	6.
为	1		30. Name and address of person w	who completed cause of	death (Item	23а) (Туре	Print) L	11/0	/ N/n	·V	Pood	R-11	MALO	Marul	and 21221
			31. Date filed (Month, Day, Year)	apairy of	XO/-/O	7 130	ICKK	114	1186	_ /	wan 1	124/1	111114 /	100/0	· V FILL
	Sta Registi		31. Date filed (Month, Day, 16al)	32,009	wes I	1	and I								
			00.1	1000											

	1 - For State Registrar	State of Marylar	nd / Depa		alth and Me	ental Hygi	iene 006	31934
Physician	1. Decedent's Name (First, Middle, La: Magnolia	st)	Har	rison		2. Date of Deatl Month	Day Year	3. Time of Death OD M
/Medical	riagnoria	a street and number)	Hat	4b. City, Town, or Lo	cation of Death	9 .	30 2006 4c. County of Death	9P M
Examiner	1506 E. 33rd			Baltim			NA	
Funeral	5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Year If		8. Date of Birth (Month, Day,	9. Birthp	place (State or Foreign
Director	220-24-4218 Usual Residence of Decedent	□ ^{M 2}	Yrs.		Tours Min.	3-30-10	0	Va.
arylar ehow det	10a. State 10b. County	10c. Ci	ty, Town or Loc				1	10d. Inside City Limits X□ Yes 2 □ No
Ba-f outfile	Md. N	A	Balti					
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygiene. Item 27 le marked other then "natural", or iteme 23a or 28a-f show other traumatic event, the Mudical Exprinter must be multipled at To Re Completed by Funeral Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Cour	ntry?
leath	1506 E. 33rd St	12. Was Decedent Ever in U	J.S. 13. W	21218		ify Yes or No-	USA 14. Race - Americ	can Indian,
The star of the st	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		as Decedent of Hispa Yes, specify Cuban, I		lican, etc.)	Black, White,	
d 2 should be filled within 72 hours aft this and Mental Hygione 77 is marked other then "natural; or traumatic event, the Medical Examitramment To Be Completed by F	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:	1	Yes 2No S	Specify:		Specify: B1	.ack
ed within 72 hounggiene. Per then "naturality, the Madical Et, the Madical Et, the Madical Et, the Madical Et.	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Decede (Give k	ent's Usual Occupation ind of work done during NOT use retired)	n ng most of workin	9	16b. Kind of Business/In	dustry
vithin ne. hen.	Elementary/Secondary (0-12)	College (1-4or 5+)					_	_
Hygie Hygie nt, the Co			Wash		. Mother's Name	(First Middle N	Laundry-C	leaner
Mental H Mental H arked ott						,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,
and Mental Hygi ie marked other summatic event,	19a. Informant's Name/Relationship (Banl Type, Print)		Address (Street and	Katie Number or Rural	Route Number,	City or Town, State, Zip	
1 and 2 Heelth a em 27 io	James Harrison	Son	150	06 E. 33rd	Street	Baltim	ore, Md.	21218
othe	20a. Method of Disposition		Place of Disposi				20c. Location - City or To	
Pages nent of I ant: if it	1	Hemoval from State T		dge Cem.	10-5	-06	Baltimore,	Md.
프트로프	21. Signature of Funeral Service Licen	\$80	22.	Name and Address of	f Facility M.	arch F.	H. East	
Dem Impo	Dlady	Waner	1	101 E. No				21202
Physician / /Medical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deat one cause on each line. a	HI	r the mode of twing, s	uch as cardiac or	respiratory arre	sst,	Approximate Interval Between Onset and Death
executed in and rial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consect.	quenc of).	- /				Zyen
sicie e bui	resulting in death) Last	Due to (or as a consec	quence of):					
Attending Physician: The law requires that the death certiticate releath. ector: Atter this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the filteration: To Be Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Ne 9 □ Unknown	23c. If yes, outcome of pregnative birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous forms.	aldeath 3⊟E	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
v requires that the debeen signed by the should be detached letted by Physic	raitii. Other significant conditions of	ontributing to death but not res	sulting in the und	derlying cause given i	n Part I.		eacco use contribute to the	
rsician: The law requir s cartificate has been s lirector, page 2 should Be Completed						24a. Was ar autopsy perform	24b. Were auto	ppsy findings available mpletion of cause of
cian: T	25. Was case referred to medical	14			6. Place of Death	Check only one	e)	
Physical this call direction To	1 10 10 10 10	Hospital: 1 Inpatient 2				-	nce 6 Other (Specif	5/)
ling F. Atter Tunera	27. Manner of Death 1	2Ba. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes		Bd. Describe ho	w injury occurred	
death death ctor: / the	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ome farm stree		2 □No	of Location (Str.	reet and Number or Rura	al Bouto Number
tal or Attending F rs after death. sal Director: After ed in by the funer. Certification:	4 Homicide determined	building, etc. (Special	fy)	at, ractory, onice		City or Town	, State)	arriodie Namber,
Hospi 4 hou Funer ely till		ysician: To the best of my knowing the control of the basis of examination and manner stated.	owledge, death ation and/or inve	occurred at the time, estigation, in my opini	date and place, a on, death occurre	nd due to the ca d at the time, da	use(s) and manner as s ate and place, and due to	stated. the cause(s)
within 2 To the complet	29b. Signature and title of certifier	\ ///		29c. License no	ımber /	29	ed. Date signed (Month,	Day, Year)
~	/ /	11/		1942	+36		10-3-	-0/
	30. Name and address of p r on AVMON Fathy	let a a f death (Ital	23a) (Type, P	OSLER A	2. #411	TOWS	en Mb. 21	204
State		32. Pegistrar's Signa	ature				η	
Registrar	COT 1 0 20	ing -	20	The same of the sa				

DHMH 17 Rev 1/2001

ORIGINAL

			1 = For State Registrar	State of M	aryland		artment of H		d Mental Hy	giene Reg. Ne	2006	31935
	Physicia		1. Decedent's Name (First, Middle	marie	Ho	NWK			2. Date of D			3. Time of Death
•	/Medic Examin	er	4a. Facility Name (If not institution HNWOYL OUNK	, give street and number,	Hospil	(a)	4b. City, Town, o	r Location of De			:. County of De	ath g.
Ī	Funeral Director		5. Social Security Number		ge (in yrs. last		If Under 1 Year Months Days 4	If Under 24 H Hours M	8. Date of Bi (Month, D			rthplace (State or Foreign country) MD
	ehow	or	Usual Residence of Decedent 10a. State 10b. County MD Anne A	Arundel	10c. City, T		cation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the N e or 28a-f be rotifi	Direct	10e. Street and Number 7153 Ohio Ave.				10f. Zip Code 21076			10g. C	itizen of What C	country?
136	n 72 hours after death with the Maryland "netural", or Iteme 23e or 28a-f ehow edical Examiner must be notilied at	by Funeral Director	11. Marital Status Mover Married 2 Marr Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 2 If Yes, Give Year or Dates:	? [No	1			(Specify Yes or N Jerto Rican, etc.)	0-	14. Race - Am Black, Wh Specify: B	erican Indian, ite, etc.
21215-0036	.n.	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	working	16b. I	Kind of Busines	s/Industry N/A
Maryland 2	B a b ≥	To Be C	17. Father's Name (First, Middle, George Hawkins	Last)					Name (First, Middle Phillips	e, Maide		
	s 1 end 2 should f Health and Mer frem 27 is marks other treumatic		19a. Informant's Name/Relations Cheri Phillips		1				Rural Route Numb		_	Zip Code)
IIImore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cem	etery, crer	sition (Name of matory or other place Memorial, I		Date '09/2006		ocation - City o	
Balt	permit. Page Depertment Important: If eny injury o		21. Signature of Puneral Service	licensee	MO1378	Ga	Name and Addre ary L. Ka 250 Washi	ufman F	Tuneral H Blvd., El	ome krid	at MMP, ge, MD	INC. 21075
	Physician		23a Part 1. Enter the disease of shock, or heart fairer has Immediate Cause (Final disease or condition	\mathcal{V}	d the death. line.	Do not ent	er the mode of dyir	ng, such as care	diac or respiratory			Approximate Interval Between Onset and Death
	/Medical Examiner	1	resulting in death) Sequentially list conditions,	Due to (or a	s a consequent of the work of	nce of):	1 Her Prem	aturi	ty			107 hr
1,0978	ate be executed hysicien end the buriel-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	s a consequer							
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rds, P	w requires that been signed b should be deta	þ	Part II. Other significant condition		but not resultin	ng in the u	mderlying cause given by s	ren in Part I.	_	tobacco	_	to the cause of death? Probably 4 Denknown
al Records,	: The law re cete hes bee ; page 2 sho	Completed								opsy formed?	prior to death	
of Vital	hysicien this certifi il director	To Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:		VOutpatier	IL SU DOA	ner: 4 Nursin	Death (Check only	sidence		ecify)
Division of	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2.	Certification:	27. Manner of Death 1	not be 28e. Place of Ir	ay Year)	Bb. Time o Injury e, farm, str	Wo	ryat rk? ∣Yes 2 □ No		(Street a	and Number or	Rural Route Number,
ā	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyir	ng Physician: To the bes	t of my knowle	edge, deat	h occurred at the ti	me, date and p	City or T	e cause(s) and manner	as stated.
	To the H within 24 To the F complete	Medical	29b. Signature and title of certifie	and manner s	stated.		29c. Licens		0		ate signed (Mo	
•	1		30. Name and address of person	who completed cause of		За) (Туре.	Print)	Colum	bira C	no a	21044	4
80	Sta Regist		31. Date filed (Month, Day, Year)	32. Regis	trar's Signatur	8	Salls .	<u></u>	-10-		- 1	1
			0017	10000		- 1						

			1 - For Amend item#16b,	State of Ma 19b, perFH,	arylan 860,	d / Depa 10/10/06	rtmer titicat	nt of H	ealth a Death	and M	ental Hy	giene Reg. No	2006) (3193	6
			1. Decedent's Name (First, Middle, La	st)							2. Date of De Month	ath Day	y Year		. Time of Deatl	n
	Physici /Medic		LAMPENES					1	ME		Detabo	4	5 200	63	500 A	. M
	Examin		4a. Facility Name (If not institution, gir	re street and number)	11	, 1	4b. City,	Town, or	Location of	of Death		4c.	County of Dea	ith		
1			The Johns	Hopkins	Hos	pital	10%	11-11	MOR	2						
н	Funeral			Sex 1 7.Aga 12AM 2□F		ast birthday) Yrs.	Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	tn ly, Yea <i>r)</i> (10/1	9. Bi	ountry)	State or Fore	ign
	Director		212-38-6138 Usual Residence of Decedent		65	110.					08/04/	1941			PA	
	/land		10a. State 10b. County		10c. City	, Town or Lo	cation							10d.	Inside City Lim	nits
	Man,	ţ	MD n/	а	В	altimore	City								1XYes 2□	No
	or 28,	Director	10e. Street and Number				10f. Zij	p Code				10g. Cit	izen of What C	country?		
	ith wi		4745 Chatford Avenue						21206				USA			
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if item 27 is marked other then "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Modical Examinar must be credited at ODEs.	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:			Was Dece f Yes, spe 1 ☐ Yes		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.))-	14. Race - Am Black, Wh Specify: B1	ite, etc.	ndian,	
5-0	72 hc	eted	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Deced	kind of wo	ork done d	turing mos	t of worki	ng	16b. K	ind of Busines	s/Indust	ry	
2121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. I	DO NOT L	ise retired)		·		• • • • • • • • • • • • • • • • • • • •	knowr		
2	led w hygier her th	S	12th	unknown		Lor	ig Sho	reman	10 Moths	ode Name	(First, Middle	Viite	STITE	KIIOWI		
Maryland	uid be fi Mental H arked ot atic ever	To Be	17. Father's Name (First, Middle, Las Omer Michael Imel								lelen Nic		Sumame)			
	alth and 2 sho		19a. Informant's Name/Relationship Kimberly Jones / Date				Chatf	ord			<i>i Route Numb</i> more, M C		or Town, State, 206	Zip Co	de)	
Baltimore,	Pages 1 a ent of He nt: If Item ry or othe		20a. Method of Disposition March Burial 2 Cremation 3 4 Donation 5 Other (Spec		0	lace of Dispo emetery, crer rison Fo	natory or	other plac		10/11/	² 2006		ocation City og $Mills$,			
Balti	permit. I Departm Importer eny inju		21. Signature of Funeral Service Lice								e Funera Baltimore					
	Dhusisian		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on each li	the death									Int	proximate erval Between aset and Death	
	Physician /Medical Examiner		disease or condition resulting in death) Sequentially list conditions,	b. Due to (or as	a consedi Sta	AT	Liv	HIC.	Si	16BA	10			4	MO	\$
	xecuted and Il-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· HEDA-	a consequence	5 (lieu	<u> </u>					32	YBAR	5_
68760,	icate be executed physicien and s the burial-transit	dical E	(a. Intra	(enoc	15	Deno	9 1	ISE					30	YEAR	1
O. Box (The law requires that the death certificate has been signed by the attending by tage 2 should be detached for use as in	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	death 3	Ectopic p						23d. Date of d Month	elivery Da	y Year	
∕gs, P.	ruires thet the de r signed by the a lid be detached f	þ	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	nderlying	cause giv	en in Part I	l.			use contribute 3□F		ause of death	
H&666/8	The law require ste hes been sis page 2 should b	Completed									24a. Was auto perf 1 ☐ Yes		<u>death</u>	autopsy comple s 2	findings availa etion of cause	able of
ia I	sian: artifica ctor.	Bec	25. Was case referred to medical examiner?	1					26. Place	e of Death	Check only	оле				
	Physician: r this certific ral director,	္	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie		ER/Outpatier			4 🗆 140				6 ☐Other (Sp	ecify)		
% 25 25 26 26 26 26 26 26 26 26 26 26 26 26 26	Attending P. r death. ector: After ti		27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	f M	28c. Injur Wor 1 🗌	∤at k? Yes 2 🏻		28d. Describe	how inju	ry occurred			
Di\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	al or Attendi s after death. If Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At ho c. <i>(Specif</i>	ome, farm, str	reet, facto	ry, office			28f. Location City or To		nd Number or i e)	Rural R	oute <i>Number</i> ,	245
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical (hysician: To the best miner: On the basis o and manner st	f examina											
=	Within To th	Σ	29b. Signature and title of certifier					c. Licens					ate signed (Mo			
	1		4	2 2	N)		1	RES.	001			Dati	Sher	5 2	200C	
			30. Name and address of person who	completed cause of c	death (Item	n 23a) (Type,	Print)	01	2 11		1	,	d 2			
	\ \		raniolph bn	OWN LO	DQ 1	4. 100	Fe	St.	SAH	MOL	B, MAC	VIAI	d 2	128	57	
302	Sta Regist		31. Date filed (Month, Day, Year)	.006 32. Registr	rar's Signa	iture	CRAN!	,				(

Certificate of Death

2. Date of Death

31937

3. Time of Death

Birthplace (State or Foreign
Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 ☐ No

Maryland

USA

Month

29d. Date signed (Month, Day, Year)

Day

Year

4:00 PM

For State Registrar

1. Decedent's Name (First, Middle, Last)

DHMH 17 Rev 1/2001

State

Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR. TARIQ MAHMOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 2006

2300 DULANEY VALLEY RD.

32 Registrar's Signature

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D43721

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland / Bepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Ody- 2006 1. Decedent's Name (First, Middle, Last) **Physician** JONES 0700 M 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PERRY HALL BALTIMORE ZIIZE SHREWSBURY CI MD If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD • If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex **Funeral** Months Days Hours Min 1₽M 2□F Yrs. 1905 213-05-2580 100 October 0 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h Counts ir than "natural", or Iteme 23a or 28a-f ehow MD Baltimore 1 Yes 2 No Perry Hall Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21128 U.S.A. 32 Shrewsbury Ct. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or item any injury or other traumatic event, it is Medical Exercity once. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: White Specify Completed by 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government 12 Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas John Jones Theresa Alethia Hedges ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 32 Shrewsbury Ct. Perry Hall Maryland 21128 Robin Boston / Grandaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/07/2006 Liberty, Maryland Central Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 10 W. Padonia Rd. Timonium Md. Lemmon Funeral Home of Dulaney Valley Inc. 21093 21. Signature of Funeral Servi anne or Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ATHEROSCLEROTIC CARDIOVASCULAR DISEASE unknown Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, Ledong to infined at cause. Enter Underlying Cause (Disease or injury Dille to (or as a nonsequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physicien s the burial Physician/Medical use as i 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Day Month Year 4□Pregnant at time of death 5 Other (specify) be detached 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by GENERATIVE JOINT 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 \(\text{No.} 2X No 1 TYes 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 [] Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Records, P.O. Box 68760, Division of Vital To the Hospital or Attending Physician:

has

with the Maryland

death

Baltimore, Maryland 21215-0036

12

State Registrar

rank 31. Date filed (Month

29b. Signature and title of certifier

32. Registrar's Sign Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Baltimore MD 2123

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Mary		artment of I rtificate of			iene _{9g. No.} 2006	31939
	Physici	an	Decedent's Name (First, Middle, Last) Devalling to To	hncon				2. Date of Deat Month October	Day Year 1 2006	3. Time of Death 11:55A M
	/Medic Examin		Phyllis W. Jo 4a. Facility Name (If not institution, give st Springbrook Rehab	reet and number)			or Location of Dec		4c. County of Death Montgome	
I	Funeral Director		5/8-22-8095	7. Age (li	93 Yrs. last birthday)	If Under 1 Year Months Days	Il Under 24 Hi Hours Mii		Year) Cou	place (State or Foreign ntry) York
	72 hours after death with the Maryland fratural, or Itama 23s or 28e-f show digat Examinal must be notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland 10e. Street and Number 5400 Vantage Point 11. Marital Status		2	olumbia 10f. Zip Code 21	044	(Specify Yes or No-	0g. Citizen of What Cou U.S.A. 14. Race - Ameri	can Indian,
Maryland 21215-0036	S 2	Completed by Fu	1 Never Married 2 Married 3 Widowed 4 Moivorced 15. Decedent's Educt (Specify only highest grade) Elementary/Secondary (0·12)	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	16a. Dece	1 ☐ Yes 2 ☑ No dent's Usual Occup kind of work done DO NOT use retire	Specify: pation during most of w		Specify: Wh:	ite
land 21	be filed ital Hygi id other avant, I	To Be Con	12 17. Father's Name (First, Middle, Last) Gust A. Wigren		Regi	stered Nu	18. Mother's N	ame (First, Middle, A le A. Laws		are
ore,	es 1 and 2 shi of Health and litem 27 ia m r other traum		19a. Informant's Name/Relationship (Type Jean Brunstetter 20a. Method of Disposition 1☐Burial 2 (QCremation 3☐Re	(Friend)	5400 20b. Place of Disponentery, cre-	Vantage osition (Name of matory or other pla	Point Ro	Date #612 (Coty or Town, State, Zing Columbia, M 20c. Location - City or T	D 21044 Jown, State
Baltimore,	permit. Page Department Important: If any injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensed	funt)	Metro Cr	rematory Name and Addre Witzke Fi 5555 Twir	ss of Facility	_	Catonsville	
	Cate be executed by American and Medical Examiner and Street by Street British and Street	Ical Examiner	23a. Part. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a co	onsequence of):	O ALLO	ng, such as cardi	ac or respirary arre	lest	Approximate Interval Between Onset and Death
.O. Box 68	he death certif the attending thed for use a:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnanc	у		23d. Date of delive	very Day Year
Δ.	The law requires that the lass been signed by page 2 should be detailed.	ρ	Part II. Dther significant conditions cont	ributing to death but n	ot resulting in the u	nderlying cause gi	ven in Part I. W		oacco use contribute to	V/
		e Completed	25. Was case referred to medical	0			26 Place of D	24a. Was an autops perform 1 Yes 2	y prior to co death? 1 ☑ Yes	opsy lindings available ompletion of cause of
ion of Vi	ding Phys h. After this funeral di	atlon: To B	examiner?	spital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time o Injury	f 28c. Inju	ner: 4 Nursing	Home 5 ☐ Reside	nce 6 □Other (Speci ow injury occurred	fy)
É	in Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, st Specify)	reet, factory, office		28f. Location (Sti City or Town	reet and Number or Rur , State)	al Route Number,
	To the Hospitel within 24 hours a To the Funeral i completely filled	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine 29b. Signature and title of certifier	pri: On the best of more: On the basis of exa	amination and/or in	h occurred at the ti vestigation, in my o	opinion, death oc	curred at the time, da	ause(s) and manner as a ate and place, and due to ad. Date signed (Month)	to the cause(s)
	8 4 £ 4		30. Name an ad ss of person who com			Print)	5614	7	10/2/01	6
	Sta Registr		Dr. Nasreen Kango 31. Date filed (Month, Day, Year) OCT 1 0 200	32. Registrar's		South Ta	akoma Pa	rk, MD 209	912	

			1 _ State		Department of Health and Certificate of Death		/111h	31940
	Physici	an	1. Decedent's Name (First, Middle, Law)	Kins	Certificate of Death	2. Date of Death	Day Year	3. Time of Death
	/Medic Examir	cal	Jeanette Jes 4a. Facility Name (If not institution, give stree	at and nymber)	4b. City, Town, on Location of Dea	October	4c. County of Death	7:19 P M
			5. Social Security Number 6. Sex	77. Age (In yrs. last birt	hday) If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthp	lace (State or Foreign
	Funeral Director		212-22-2699 1□M Usual Residence of Decedent	attack and	Yrs. Months Days Hours Min	Mar. 18	ear) Coun	
	Maryland -f ehow lied al	tor	10a. State 10b. County Mandand NA	10c. City, Town	Battimare		1	od. Inside Øity Limits 1 ☑ Yes 2 ☑ No
	death with the Maryland rms 23a or 28a-f ehow r must be notified at	Funeral Director	10e. Street and Number 2422 Wellbridge	Drive Apti	4 10f. Zip Code 21234	10g	. Citizen of What Coun	liàs
020		b	1 Newer Married 2 Married	Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Tho If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (solid Yes, specify Cubar, Mexican, Puer 1 Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White Specify:	
0-61717	within 72 hours after iene. r then "netural", or Ite	Completed	15. Decedent's Education (Specify only highest grade co		Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) HOMEMAKEY	orking	b. Kind of Business/Inc	dustry
ומוומ ז	ould be filed I Mental Hygi Narked other	To Be C	17. Father's Name (First, Middle, Last) Rafph Stokes			me (First, Middle, Ma	iden Sumame)	
, Mary	and 2 sho leelth and M m 27 le ma		19a. Informant's Name/Relationship (Type,	5 2	Mailing Address (Street and Number or E The Wellbridge D	ural Route Number, C	Eity or Town, State, Zip A Baltin	code) 21234- Note, Md.
	Pages 1: ment of He ant; If iten ury or oth		20a. Method Disposition 1 Durial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	oval from State cometer	Disposition (Name of by, crematory or other place) ORE CEMETERY 10	Date 20	c. Location - City or To Ethinore,	wn, State Maryland
Dall	permit. Pages Depertment of Important; If it eny injury or once.		21. Signature of Funeral Service Licensee	arken	22. Name and Address of Facility Per 3512 Frederick A	rker Funer. R. Baltim		nd 21229
	Physician		23a. Part 1. Enter the disease, or complicati shock, or heart failure. List only one of Immediate Cause (Final disease or condition	ons that caused the death. Do nause on each line.	not enter the mode of dying, such as cardia	or respiratory arrest	. /	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of	ous cerebral V	ascular.	Accident	
ex	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence of Sick 5/n)				
, ,0070	icate be executed physician and s the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a consequence of	andiac Paceur	alle		
O. BOX O	The law requires that the death certific ate has been signed by the ettending p page 2 should be deteched for use as:	Physician/Med	in the past 12 months?	If yes, outcome of pregnancy 1∏Live birth 2 ∏Fetal death 4∏Pregnant at time of death 9∏Unknown	3 ⊟Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ry Day Year
ords, r.	uires that t signed by Id be deter	by	Part II. Other significant conditions contrib	uting to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?
r L	The law req te has beer age 2 shou	Completed				24a. Was an autopsy performe	g? death?	osy findings available inpletion of cause of
VIIA	sician: certifica rector, p	Be	25. Was case referred to medical examiner?	pital:	Othor	eath (Check only one)		
5	ing Phys Viter this uneral di	on: To	1 162 2 NO	8a. Date of Injury 28b. T	Time of niury at Work?	28d. Describe how	e 6 Other (Specify injury occurred	/)
JIVISION	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has complately filled in by the funeral director, page 2	Certification:	2 Accident investigation	Re. Place of Injury - At home, far building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Stree City or Town,	et and Number or Rura State)	l Route Number,
-1	Hospital	edical Ce	(Check only 2 Medical Examiner:	On the basis of examination and	o, death occurred at the time, date and placed/or investigation, in my opinion, death occ	e, and due to the causurred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To the within 2 To the complai	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number	29d	. Date signed (Month,	Day, Year)
	n		30. Name and address of person who comp	deled cause of death (Item 23a) (7ype, Print) 2		10/6/06	
			3601 O'Donnell	Ther Ball	O. M&, 2/22	4		
	Sta Registi		31. Date filed (Month, Day, Year) OCT 1 0 2006	2. Registrar's Signature	parti			

			1 - For State Registrer	State of Maryland	d / Depa <i>Cei</i>	artment of F rtificate of i	lealth and I Death		iene2 () () (•g. No.	5 31941
	Physici	an	Decedent's Name (First, Middle, Last)	4				2. Date of Deat Month	Day Yea	
	/Medic	al	JOHN E 4a. Facility Name (If not institution, give :	Kearne	7_	4h Cihi Town o	r Location of Death	10	4c. County of De	
	Examir	er	Johns Hoplen		r	-	Humos		Cit	
	Funeral Director		5. Social Security Number 6. Sep. 3/4-40-6469 1X			If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 44 N	hirthplace (State or Foreign Country) ORTH CAROLIWA
	fand ow		Usual Residence of Decedent 10a, State 10b, County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	a-f eh	tor	MARYLAND N	/A		BA	LTIMO	RE C	171/	1 Yes 2 No
	or 28	Dire	10e. Street and Number	THE LANGE OF	~~~	10f. Zip Code	2121	1	Og. Citizen of What	Country?
	eath v	Funeral Director	4910 CRENS	12. Was Decedent Ever in U.S.	1 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race · Ar	nerican fridian,
21215-0036	n 72 hours after death with the Maryland "neture!", or itema 23a or 28a-f ehow adical Examinar must be invitted at	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 A Yes 2 □ No If Yes, Give Year or Dates:		if Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	o Rican, etc.)	Specify:	
5-0	22 23	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give	dent's Usual Occup	during most of wor		16b. Kind of Busines	ss/Industry
121	within ene. then "	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	lite.	DO NOT use retired	JORKE	R	(BETHIF	HEM STEEL
	filled Hygi ther	a	17. Father's Name (First, Middle, Last)	YKS		1 CCL V		ne (First, Middle, I		12/11/01/22
ylar	Mental Mental arked c	To B	HORACE	J	ONE	<u>-</u> 5	Luci	LLE	KE	ARNE I
Maryland	and and is m		19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address Street	and Number or Ru	ral Route Number	; City or Town, State	a, Zip Code)
-	1 end 2 Health tem 27		ANIKA KEARNE 20a. Method of Disposition	/ 20b. PI	ace of Dispo	esition (Name of	JELL 1	Date	20c. Location - City	or Town, State
ē	00		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	lemoval from State		natory or other place	'	4-06	ARBUTO	US MARKAND
Baltimore	permit. Peg Department Importent: f any injury o		21. Signature of Funeral Service Licens		22	2. Name and Addre	ss of acylity (ROWN ON AVE	R. FUN	ERAL HOME, MO 21217
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death	. Do not en	er the mode of dyir				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	ASCUI)					Onset and Death Years
1	/Medical Examiner		Todaking in double)	Due to (or as a consequ	ence of):					1 ATM 12
	à.	Jer	Sequentially list conditions, if any, leading to immediate	Due to (dr as a consequ	ience of):					400
	ocuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. Dishet	es					years
60,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):					
58760,	icate physi s the l	edicai		d						
.O. Box (The law requires that the death certificate hes been signed by the ettending lage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	1		23d. Date of o Month	delivery Day Year
<u>α</u>	s that ned by e deta	by Ph	Part II. Other significant conditions con	ntributing to death but not resu	ılting in the u	nderlying cause giv	ren in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
ords	w requires been sign should be					· · · · · · · · · · · · · · · · · · ·		1 □ Y	es 2□No 3□	Probably 4 Dunknown
Il Records,		Completed						24a. Was a autops perform	med? prior to death	autopsy findings available to completion of cause of ? es 2□ No
Vital	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospitaf:		oth Oth	05	ath (Check only on		
of		7.	1 ✓ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	ER/Outpatie 28b. Time o	IL 3L DOA	4 Nursing F		ence 6 Other (S	pecify)
ion	death. ctor: Afte	atio	1 Natural 5 Pending investigation	(Month, Day Year)	Injury		Yes 2 □ No			
Division	ospital or Attend hours after death uneral Director: , ly filled in by the f	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At ho building, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	Medical	(Check only 2 Medical Exami	sician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, deat ion and/or in	vestigation, in my o	pinion, death occu	irred at the time, d	ate and place, and o	due to the cause(s)
	Vith To t	Σ	29b. Signature and title of certifier	. (1)		29c. Licens		2	9d. Date signed (Mo	onth, Day, Year)
			100 None	MP OF THE OWNER OF THE PARTY TO	23a\ /T		\$624		10/07	1 6006
	(px)		30. Name and address of person who co	estman	MO (Type,	Tou	MS H	robin	Boyu	rew
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture			7		
	Regist	rar	OCT 1 0 20	06 Marie	G. A	parti				

		1 - State of Man	yland / Depa <i>Ce</i>	artment of Health and N <i>rtificate of Death</i>	Mental Hygien Reg. N	2006 31942
Physi	cian	Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
/Med	lical	Mary Margaret Kri 4a. Facility Name (If not institution, give street and number)	ckbaum	4b. City, Town, or Location of Death	October 0	2, 2006 1212 P M
Exam Funera Directo	al	1225 Stella Drive 5. Social Security Number 6. Sex 7. Age (1 20-20-9058 7. Age (1 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	In yrs. last birthday) Yrs.	Woodlawn If Under 1 Year II Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Baltimore 9. Birthplace (State or Foreign
land ow		Usual Residence of Decedent 10a. State 10b. County 1	Oc. City, Town or Lo	ocation		10d. Inside City Limits
Mary	tor	Maryland Baltimore	Woodla	ıwn		1 ☐ Yes 2 📆 No
or 28	Director	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?
eath w	Funeral	1225 Stella Drive 11. Marital Status 12. Was Decedent Eve	er in IIS 13	Was Decodent of Hispanic Origin? (Sr		d States of America 14. Race - American Indian,
15-UU36 72 hours after death with the Maryland *netural; or Itama 23a or 28a-f ehow odles! Examinar must be notified at	b	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: White
Z1Z13~UU36 d within 72 hours af piene. r then *netural; or the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king 16b.	Kind of Business/Industry
8 5	Son	12 0		Home Maker	One (First, Middle, Maide	wn Home
E 8 2 2 2	o Be	Leo B. Kelly		Mary T.		an Sumamey
Maryla d 2 should I th and Meni 7 is marke	F	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number or Ru		or Town, State, Zip Code)
- c= ~ L	1.	Mary Tacka (Niece)	4 S11	ktree Court, Cato	nsville, M	aryland 21228
altimore, I		1 XBurial 2 Cremation 3 Removal from State	cemetery, crei	matory or other place)	. None	
baltimor permit. Pages Department of I Importent: If Ite any Injury or of		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses		Cemetery 10/0		dlawn, Maryland Funeral Directors,I
Dep m		23a. Party. Enter the disease, or complications that caused the				
icate be executed physicien and physicien and sine burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a c c	consequence ol):			
death certiti	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
law requires that the de as been signed by the	þ	Part II. Other significant conditions contributing to death but r	not resulting in the u	inderlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
The la	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ysician: Tysician: Sertificel	Be	25. Was case referred to medical examiner?			th (Check only one)	
_ × v ō	5	1 Yes 2 No 1 Inpatient			ome 5 Residence 28d. Describe how in	
nding Ph nth. r: After th e funeral	ation	27. Manner of Death 1 Natural 5 Pending (Month, Day Young) 2 Accident investigation	ear) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		ary december
LIVISION tal or Attending s atter death. Illustrictor: Afte	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (- At home, larm, str Specify)	reet, lactory, office	281. Location (Street: City or Town, Sta	and Number or Rural Route Number, ite)
To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely tilled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of n 2 Medical Examiner: On the basis of example and manner state.	camination and/or in	th occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause rred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
Vith To t	Σ	29b. Signature and title of certifier	~ 1	29c. License number	29d. 0	a signed (Month, Day, Year)
		In Myllisk MM Ila	ytuty	1)18667	0	tober 7, 2006
V		30. Name and address of person who completed cause of deal Philip Militello, MD	6 Tru	nble Hill CT. Lu	theru: le	Md 21093
S Regis	tate trar	31. Date liled (Month Day, Year) 32. Fedistrar's OCT 1 0 2006	Signature	back		

cian dical niner 4	1. Decedent's Name (First, Middle, Last) HOMAS 1a. Eacility Name (If not institution, give si							
1	THE JOHAL HOPK	treet and number)	Pital	KNOX 4b, City, Town BAH	or Location of Dea	2. Date of Dea Month ONE ith	Day Year Year Ac. County of De	508 22 48 P
1.1	5. Social Security Number 6. Sex	7. Age (1. M 2□F	n yrs. last birth 84	day) If Under 1 Years. Months Day	r If Under 24 Hr		r, Year)	irthplace (State or Forei Country) N.C.
to	10a. State 10b. County Nd . N	IA 10	Oc. City, Town	or Location Baltimore				10d. Inside City Lim 1 X Yes 2 ☐ I
al Dire	10e. Street and Number 1400 E. Madison S	Street Apt.	. 251	10f. Zip Code	.205		10g. Citizen of What 0 USA	Country?
5	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:	r in U.S.	13. Was Decedent of If Yes, specify Co		Specify Yes or No- rto Rican, etc.)	14. Race - An Black, Wh Specify: E	
To Be Completed by F	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 2nd grade	ation completed) College (1-4or 5+)		Decedent's Usual Occ Give kind of work don life. DO NOT use reti Housekeepi	ne during most of wo red)	orking	16b. Kind of Busines State of	ŕ
To Be	17. Father's Name (First, Middle, Last) Will	Kr	nox	iioubenee <u>p</u> i		ame (First, Middle, Lie		
	19a. Informant's Name/Relationship (Typ Joseph M. Hall	Guardian		4210 Dress		Randalls	r, City or Town, State town, Md.	Zip Code) 21133
2	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 4 □ Conarion 5 □ Other (Specify)	1	cemetery,	Disposition (Name of crematory or other p		Date -5-06	20c. Location - City of Randallst	
	21. Signature of Funeral Service Licenses	Upters	Dr		North Ave	e., Balti	F.H. East more, Md.	21202
cal Examiner	23a. Par M. Enter the disease, or complice stack or heart failure. List only one limme diate Cause (Final disease of condition resulting in death) S. hurnitally list conditions, if am, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	a cause on each line. SEPTO Due to (or as a complete to (or a))).	SI- onsequence of Sonsequence of	(OCK):				Approximate Approximate Interval Between Onset and Death 2 DATS
	IF FEMALE: 23 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of p 1 Live birth 2 4 Pregnant at tim 9 Unknown	Fetel death	3 □Ectopic pregnar 5 □ Other (specify)	псу		23d. Date of d Month	elivery Day Year
à	Part II. Other significant conditions cont	ributing to death but n	ot resulting in t	he underlying cause o	given in Part I.	23e. Did to	1.	to the cause of death?
Completed						24a. Was a autop: perfor 1 Yes	sy prior to med? death?	autopsy findings available completion of cause of the cau
To B	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Ye	2 ER/Outp 28b. Tir 9ar)	ne of 28c. In	ther: 4 🗆 Nursing		ence 6 Other (Spow injury occurred	ecify)
Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	- At home, farn Specify)	n, street, factory, offic	е	28f. Location (S City or Tow	treet and Number or I n, State)	Rural Route Number,
edical	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examination	cian: To the best of mer: On the basis of exand manner stated	amination and/	death occurred at the or investigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time, o	ause(s) and manner late and place, and di	as stated. ue to the cause(s)
≥ 2	29b. Signature and title of certifier DANKL DURAND. 30. Name and address of person who con	MEDICAL DOC	TOR		- OCC		end Date signed (Modern Person	75, 700 25, 700 21287

Figure F	Itimore Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No at Country? SA American Indian, White, etc.
Funeral Director Fig. 2006 Funeral Director Funeral Director Control of December Control of Decemb	Death Itimore Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No at Country? SA American Indian, White, etc.
5725 Oakland Road Funeral Director Social Security Number 6. Sex 1	Itimore Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No at Country? SA American Indian, White, etc.
Funeral Director 5. Social Security Number 218-14-1495 G. Sex 1 M A F Reg (In yrs. last birthday) 1 M A F Reg (In yrs. last birthday) 82 Yrs. 1 Months Days Hours Min. (Month, Day, Year) NOV 6, 1923	D. Birthplace (State or Foreign County) Maryland 10d. Inside City Limits 1 Tyes 2 X No at Country? SA American Indian, White, etc.
Director 218-14-1495 1 M 20 F 82 Yrs. Months Days Hours Min. (Month, Day, Year) NOV 6, 1923 Usual Residence of Decedent	10d. Inside City Limits 1 Tyes 2 No at Country? SA American Indian, White
Usual Residence of Decedent	10d. Inside City Limits 1 ☐ Yes 2 🛣 No at Country? SA American Indian, White, etc.
10a. State 10b. County 10c. City, Town or Location	1 Tyes 2 No at Country? SA American Indian, White, etc.
Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of White 10e. Street and Number 10f. Zip Code 10g. Citizen of White 10f. Zip Code 10g. Citizen of White 10f. Zip Code 10g. Citizen of White 10f. Zip Code 10g. Citizen of White 10f. Zip Code 10g. Citizen of White 10f. Zip Code 10g. Citizen of White 10f. Zip Code 10g. Citizen of White 10f. Zip Code 10g. Citizen of White 10f. Zip Code 10g. Citizen of White 10f. Zip Code 10g. Citizen of White 10f. Zip Code 10g. Citizen of White 10f. Zip Code 10g. Citizen of White 10f. Zip Code 10g. Citizen of White 10f. Zip Code 10g. Citizen of White 10f. Zip Code 10g. Citizen of White 10g. Citizen of White 10f. Zip Code 10g. Citizen of White	at Country? SA American Indian, White, etc. White
10e. Street and Number Street and Number 10f. Zip Code 10g. Citizen of Wh.	SA American Indian, White, etc. White
State Stat	American Indian, White, etc. White
11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 3 Never Married 2 Married 2 Married 3 Never Married 2 Married 3 Never Married 2 Married 3 Never Married 2 Married 3 Never Married 2 Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never	White, etc. White
1 Never Married 2 Married 1 Yes 2 Mo 1 Yes 2 Mo 3 Widowed 4 Divorced Year or Dates: 1 Yes 2 Mo Specify: Spec	
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Sive kind of work done during most of working life. DO NOT use retired)	
(Give kind of work done during most of working life. DO NOT use retired)	1633/11GUSTI y
Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own	Home
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
Carl Schaefer Anna Laage	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta	ate, Zip Code)
Carroll M. Koslowski, Sr./Husband 5725 Oakland Road Arbutus. MD 2122	2.7
20b. Place of Disposition (Name of cemetery, crematory or other place)	
1 Zaurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Agents of Disposition 1 Zaurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Memorial Park Park	e. MD
21. Signature of Funeral Service Licensee 22. Name and Address of Facility MacNabb Funeral Hon	
Edward A. Gregorchik 21. Signatures Funeral Hone 22. Name and Address of Facility MacNabb Funeral Hone 301 Frederick Road Catonsville, I	1D 21228
23a. Part 1. Enter the diseater or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Physician Immediate Cause (Final disease or condition Congestive Heart Farlure	Onset and Death
/Medical resulting in death) Due to (or as a consequence of):	
Examiner Sequentially list conditions	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
the burns of the b	18
The part of Market 1 and 1 an	- V
FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 23d. Date of Month 1 Nother significant conditions continued to the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 23d. Date of Month 2 Fetal death 3 Ectopic pregnancy 23d. Date of Month 1 Nother significant conditions continued to the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 23d. Date of Month 2 Fetal death 3 Ectopic pregnancy 23d. Date of Month 2 Fetal death 3 Ectopic pregnancy 23d. Date of Month 2 Fetal death 3	
1 Yes 2 Who 9 Unknown 9 Unknown	
1 Yes 2 Who 9 Unknown 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part II.	ute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	☐ Probably 4 ☐ Unknown
1 Yes 28No 3	C. C. C. Lella
24a. Was an autopsy performed dea	re autopsy findings available or to completion of cause of ath?
1 Yes 2 1 No 1	Yes 2□ No
243. Was an autopsy performed? 25. Was case referred to medical examiner? 1	
1 Yes 2 12/No Positive 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 12/No injury occurred	
28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Work? 28d. Describe how injury occurred Injury Work?	
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Manger of Death 1 Maturat 2 Accident 2 Accident 2 Accident 3 Suicide 4 Homicide 4 Homicide 28b. Place of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Place of Injury 4 Homicide 28c. Injury at Work? 1 Yes 2 No 28c. Place of Injury at Work? 28c.	or Rural Route Number.
4 Homicide determined building, etc. (Specify)	
Cause (Disease accordingly to the property of	er as stated.
29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one)	due to the cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (//	Month, Day, Year)
1019/	06
30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	2 71218
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

				State of Maryla perFH,G860, 10/2	Cei	rtificate of L	Jeam		Reg. No. 2006	31945
			Registrar 1. Decedent's Name (First, Middle, Last					2. Date of	Death	3. Time of Death
	Physicia /Medic		Ruth L.	Kuhn				Octob	er 5, 2006	1:30 a ^M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or			4c. County of De	ath
			4802 Parkside I		rs. last birthday)	Balti If Under 1 Year	more (N/A	irthplace (State or Foreign
	Funeral Director			M 2 13√F 8		Months Days	Hours	Min. (Month,	Birth Day, Year) 192 5 9. B	NC
7	2 >		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	42				
Approp	shoy	ō	MD N/A		Baltimor					10d. Inside City Limits 1 □∀es 2 □ No
9	7.28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What 0	Country?
1	23a o	ai D	4802 Parkside D	rive		21206			USA	
5-0036	s rature a should white the warylar of the property of the property and Mental Hygiene. If Health and Mental Hygiene. If Health and Mental Hygiene. Other traumatic event, I've Medical Examinar must be notified at	l by Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2XI No	spanic Origi n, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)	No- 14. Race - Am Black, Wh Specify: W.	nite, etc.
5-0	"natu	etec	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation fu <i>ring</i> most o	of working	16b. Kind of Busines	s/Industry
121	than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		phone Oper			Banking	
102	al Hygiene.	ø	17. Father's Name (First, Middle, Last)		10101	MONE OPEL		's Name (First, Midd	dle, Maiden Surname)	
arylar	Mental Mental arked o	To B	Charles Hodson				Eliz	abeth Ri	chardson	
ž g	of Health and I tem 27 Is mail tem 27 Is mail tem 27 Is mail tenums		19a. Informant's Name/Relationship (7) Charles Kuhn/Hus		1	ng Address (Street a		or Rural Route Num Baltimor	mber, City or Town, State,	
Baltimore,	Department of He Important: If iten any injury or oth once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F `4 □ Donation 5 □ Other (Specify)	Removal from State		natory or other place		Date 0-09-2006	20c. Location - City of Baltimore	
Ball	Depart Import any inj		21. Signature of Funeral Service Licens	see		. Name and Addres		Cvach/Ro	sedale Fune: dale MD 21:	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the denoted in a cause on each line.						Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition resulting in death)	a. PANCR.	EATIC	CANCE	ス			Onset and Death 4 MONTHS
	/Medical xaminer		resulting in dealth)	Due to (or as a cons	sequence of):					
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petito	nd transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	с						
.8760,	physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a cons	sequence of):					
		edical	•	d						
O. Box 6	igned by the attending be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of do Month	elivery Day Year
Q 4	ned by e deta	by Ph	Part II. Dther significant conditions co		resulting in the u	nderlying cause give	n in Part I.	23e. Di	d tobacco use contribute	to the cause of death?
ords	been sig	ted t	HYPOTHYROI	DISM				1[∏Yes 2∭KNo 3∏F	Probably 4 Unknown
I Records, P.O	ate has be	Completed							topsy prior to formed death?	autopsy findings available completion of cause of
of Vital	is certificate	Be	25. Was case referred to medical examiner?	A				of Death (Check onl		
of Physi	0 5	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2	ER/Outpatien	t 3 DOA Othe	or: 4 □ Nurs		esidence 6 Other (Sp	ecity)
	th. : After thi	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year		Work	a. ∕es 2 ∐No		ne now injury occurred	
Division Lor Attending	or dea	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str	eet, factory, office			(Street and Number or F	Rural Route Number,
	rs afte		T C TOTAL OF THE PARTY OF THE P	building, etc. (5)				Only of	Town, State)	
ре Новр	within 24 hours after death. To the Funeral Director: A completely filled in by the t	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or in	occurred at the time vestigation, in my op	e, date and pinion, death	place, and due to the control occurred at the time	ne cause(s) and manner a le, date and place, and du	as stated. ue to the cause(s)
To	To T	Σ	29b. Signature and title of certifier	nen	- Ora	29c. License		0	29d. Date signed (Mor	
5	1		30. Name and address of person who co	ompleted cause of death (I	tem 23a) (Type,	Print) 760 BA	2 B	MECAIR 12 MD 212	2040	
	Sta Registra		31. Date filed (Month, Day, Year) OCT 1 0 20	32. Registrar's Sig	gnature	lessels?				

			1 = For State Registrar	d Ite	State on 26 p	of Maryla er verl	nd / Depa 3 G860	artmer 10/1 tillica	nt of H	ealth a	and N	1ental	Hygie Reg	ene 0	06	319	146
	Physici	an	Decedent's Name (First,									2. Date Month	h	Day	Year	3. Time of	
	/Medi		Robert T. 1									Sept	embe	r 8	2006	5:30p	m M
	Examir	ier	4a. Facility Name (If not ins.			ımber)				Location	of Death				ty of Death		
		10	11708 Balsawo	od Te		7 Age (In ye	s. last birthday)		rel	If Under	24 Hrs	8. Date	of Dieth	Prin		orge's	- Ci
	FuneralDirector		579-20-7694		M 2□F	83	Yrs.	Months		Hours	Min.	(Mont	h, Day, Y	(ear)	Cour	olace (State or ntry) Lngton,	TDC
	13E (h. 146)		Usual Residence of Decede	nt		- 03						Jair.	10,	1723	Washi	ing con,	, 50
	nylan how		10a. State 10b. C	ounty		10c. C	City, Town or Lo	cation							1	0d. Inside Cit	y Limits
	e Ma	cto	MD Pri	ice Ge	orge's	L	aure1									1 XYes	2 No
	th with th	al Dire	10e. Street and Number 11708 Balsawo	od Te	rrace				708				10g	. Citizen o	f What Cour	ntry?	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23e or 28e-f ehow with injury or other traumatic event, the Medical Examinating training a pance.	by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 Div		12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	2y∑ No ive		Was Dece f Yes, spe 1 Yes	cify Cuba	spanic Ori n, Mexicar Specify:	igin? (Sp n, Puerto	ecify Yes o Rican, etc	or No-		ace · Americack, White,	etc.	
2-0	72 ho natur	ted	15. Dec (Specify only	edent's Edu			16a. Dece	dent's Usu	al Occupa	ation	t of work		16	b. Kind of	Business/In	dustry	
21	thin e	Completed	Elementary/Secondary (0		College (life.	DO NOT	ise retired,	<i>luri</i> ng mos)	t of work	ing					
	ed wi	S	12				Pos	tal V	lorke					overn			
lud	be fil tal H d otf	Be	17. Father's Name (First, M.		1 0								iddle, Ma	iden Suma	ime)		
<u> </u>	i Men Marke Marke	10	Robert T. K							Katie							
, Maryland	and 2 shealth and 27 is m		19a Informant's Name/Rela			aughte	19b. Mailir 11708	Bals	s (Street a	d Ter	r or Rura Crace	al Route N Lau	rel,	MD 2	n, State, Zip 0708	Code)	
ore	of He of He fitan		20a. Method of Disposition 1 🔀 Burial 2 □ Crema	tion 3 □E	Romaval from	I	Place of Dispo	sition (Na	me of other place	9)	(Date	20	c. Location	- City or To	own, State	
Ĕ	Pag ment ant: I ury o		4 Donation 5 Oth				Linco	ln Ce	emete	ry S	ept.	14,20	006	Brent	twood,	MD	
Baltimore,	permit. Depart Import ony inj		21. Signature of Europat Sc	vice Licens	99										ins Fu C 200	neral 11	Home
94	ŧ.		23a. Part1. Enter the disea shock, or heart failure	se, or compl List only o	ications that one cause on e	caused the dea	ath. Do not ent	er the mod	de of dying	, such as	cardiac o	or respirate	ory arrest			Approximate Interval Betw	veen
	Physician		Immediate Cause (Final disease or condition		Ath	24056	genot.	ic C	And	insta	Seed	a F	Jean 1	+ 70	٠. هم ١٠٠	Onset and D	
	/Medical		resulting in death)		Due to	(or as a conse	quence of):			-00.	3 4		, , ,	C 377.	1	<u> </u>	
	Examiner		Sequentially list conditions.		b												
	be #is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	7	Due to	(or as a conse	quence of):										
	and I-tran	хаш	that initiated events resulting in death) Last		c	(or as a conse	auanna of):										
8760,	ficate be executed physician and s the burial-transit	E			Due to	(Or as a Cunse	quanca on):										
387	physis the	dical			d. ———												
Θ	eath certifi attending for use as	n/Me	IF FEMALE: 23b. Was decedent pregna	nt 2		tcome of pregr								23d. D	ate of delive	erv	
P.O. Box	the the	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			pirth 2∏Fei nant at time of own		Ectopic p Other (st					_	М	lonth	Day Y	ear
۳.	that if	/ Ph	Part II. Other significant co	nditions co	ntributing to d	eath but not re	sulting in the ur	nderlying o	ause give	n in Part I.		23e.	Did tobac	co use cor	ntribute to th	ne cause of de	eath?
rds,	quires tha n signed l	d by	PARHINSO										1 🗌 Yes	2100	3 Prob	ably 4 ∐Ur	nknown
Ö	w requir s been si should	lete	Demesti	<i>e</i> : .								24a.	Was an	24b	Were auto	psy findings a	vailable
Вe	ysician: The lav is certificate has director, page 2	Completed	CHUCK			* *							autopsy performe	d?	prior to cor death?	mpletion of ca	use of
ā	ician: Th certificate ector, pag	O	25. Was case referred to m							26 Place	of Death	1 Check of		No	1 🗌 Yes	2 No	
>	ysici is cer direci	0 B	examiner?	F	lospital:	Inpatient 2[ER/Outpatien	t 3□ D0	Othe	r				e 6 🗆 Ot	ther (Specify	v)	
O	Attending Physician: r death. ector: After this certifice by the funeral director.	L:u	27. Manner of Death		28a. Date		28b. Time of Injury		28c. Injury Work	at				injury occu		<u></u>	
Ö	ath. or: Af	atic	2 Accident	ending vestigation	(10.07)	in, Day roan,	anjury .	М		es 2 🗆 l	No						
Division of Vital Record	Hospital or Attenc 14 hours after death Funeral Director: tely filled in by the	Certification:		ould not be etermined		of Injury · At I ing, etc. (Spec	nome, farm, str ify)	eet, factor	y, office				on (Street r Town, S		iber or Rura	l Route Numb	90 <i>1</i> ,
	To the Hospital or Attending Pheithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical (29a. Certifier 1 Certifier (Check Only one)	tifying Physical Exami	ner: On the b	best of my kr asis of examir ner stated.	owledge, death ation and/or inv	occurred restigation	at the time	e, date and inion, deal	d place, a	and due to ed at the t	the caus	se(s) and m and place	nanner as st , and due to	ated. the cause(s)	
	To the within 2 To the c. mple	Me	29b. Signature and title of c	ertifier				290	c. License	number			29d.	. Date sign	ed (Month,	Day, Year)	-
			Selan	GOV/	162	to Do			Hos	557	27		5	ento	la.	30 2	-
			30. Name and address of pe		1		m 23a) (Type,	Print)						1	no v		- 6 ×
									وتساسي	CL	إسراف	d.	1911	vz /0	mid	30,2	
4	Sta	3000	SALVADON 31. Date filed Manning Day,	7006	32. F	legistrar's Sign	ature	,	1			01		1			
	Registr	ar	-0. I 0		F. 13 BULL	155	CHARLES OF A										

			1 - For State Registrar	State of Maryla	and / Depa <i>Cei</i>	artment of F	lealth and <i>Death</i>		giene 006	31947
	Physici /Medic		Decedent's Name (First, Middle, Last	Ernest F	. Klemm			2. Date of Dea Month	th Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give Union Memorial Ho			4b. City, Town, or Baltim		ath	4c. County of De	ath
	Funeral Director			9X 7. Age (In y.	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		9. Bi 1920 MD	rthplace (State or Foreign country)
	Maryland f show	or	Usual Residence of Decedent 10a. State N/A	10c.	City, Town or Lo		timore			10d. Inside City Limits
	with the ta or 28a-	Direct	10e. Street and Number 4401 Roalnd Avenu	ue Apt. 503		10f. Zip Code 212	10	1	U.S.A.	Country?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, the Medical Evantinar must be rediffied at once.	by Funeral Director	11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates:			lispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
21215-0036	ithin 72 hou le. len "nature l Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired Pressman	during most of w	rorking	16b. Kind of Busines:	
and 21	d be filed w ntal Hygier ed other the	Be	12 17. Father's Name (First, Middle, Last) Philip F. Klemm			rressilari		ame (First, Middle, I	Maiden Sumame)	
Maryland	d 2 should be the and Mental I I I is marked of traumatic evertance	To	19a. Informant's Name/Relationship (7 Mona Klemm (Wife)	ype, Print)		-	and Number or i	Rural Route Number	r, City or Town, State, Balto, M	
Baltimore,	Pages 1 an ant of Heal it: If item 2 y or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State Me	b. Place of Dispo	sition (Name of	ca) I	Date	20c. Location - City of Catonsville	r Town, State
Baltir	permit. F Departme Importar any Injur		21. Signature of Funeral/Service bica		Bi 36	Name and Address 1rgee-Hens 31 Falls	ss of Facility SS-Seitz Road I	z Funeral Balto, MD	Home Inc	•
	Pnysician /Medical		23a. Part 1. Ehter the disease, or comy shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aRespir	eath. Do not ent		g, such as cardi			Approximate Interval Between Onset and Death 24 ay 1
	Examiner	-ia	Sequentially list conditions,	b. Due to (or as cons	thre He	at Fail	lure			4 days
du	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Acate Due to (or as a cons	Tenal sequence of):	Fullere				Zdays
68760, 7	fficate be g physician is the buri	edicai		d. Corona	r ont	ry Dise	ase			Syears
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours alter death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filted in by the funeral director, page 2 should be deteched for use as the burial-transit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ Fi 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	blivery Day Year
rds, P.	quires that I n signed by uld be deta	by	Part II. Other significant conditions of				en in Part I.		bacco use contribute es 2 □ No 3 □ F	to the cause of death?
Division of Vital Records,	The law require ate has been sig page 2 should t	Completed		ypc2, Interst				24a. Was a autops perform	y prior to	
Vita	ician: certific rector.	Be	25. Was case referred to medical examiner?	Hospital:		oth	00	eath (Check only on		
on of	ding Phys h. After this funeral di	tion: To	1 Yes 2 Too 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun	4 - Indiani		ence 6 Other (Spanson injury occurred	ecify)
Divisi	al or Atten after deal Director: d in by the	Certification:	3 Suicide 6 Could not be determined		t home, farm, streetify)			28f. Location (St City or Town	reet and Number or F n, State)	iural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filted in by the funeral director, page 2	Medical C	29a. Certifier Certifying Ph. 2 Medical Exam	ysician: To the best of my kiner: On the basis of examiner and manner stated.	knowledge, death ination and/or inv	n occurred at the tin vestigation, in my o	ne, date and pla- pinion, death oc	ce, and due to the co	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within To the comp	Ž	29b. Signature and title of certifier			29c. License			9d. Date signed (Mon	
			Sliphen / Cyur	1	tom 220\ /T =				chuber 08,	
	D		Stephen Navyen, mo	In a Manaral H	10m 23a) (Type,	East Univer	sily Perk	way Balfin	w. MO 212	18
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 0 2	Manager of death (III)	gnatura	sadi.		1		

				State of Maryla				•	iene	
			1 - For State Registrar			rtificate of			g. No. 2006	31948
Е	Physic	ian	1. Decedent's Name (First, Middle, La Frank Vincent	•				2. Date of Death Month	Dav Year.	3. Time of Death Q:07 AM
100	/Medi Examir		4a. Facility Name (If not institution, gi			4b. City, Town, o	r Locetion of Death		4c. County of Deat	
			Franklin Squa	re Hospita	-1	Ruse	edule		Balti	more
	Funeral Director		5. Social Security Number 216-03-2127	Sex 7. Age (In y	rs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 08/05/1	9. Birth	nplace (State or Foreign untry) NSYVania
	ō		Usual Residence of Decedent					700/00/1	1011	
	f show	5	Maryland Ba	altimore	City, Town or Le	arkville				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	r 28a-	lrect	10e. Street and Number		-	10f. Zip Code		10	g. Citizen of What Co	untry?
	death with the Maryland rme 23s or 28s-f show	ralD	8800 Walther Blv	•			1234		U.S.A.	
	be filed within 72 hours after death with the Marylan Hygiene. Id other than "natural", or Iteme 23a or 28a-f show ont, the Madical Examinate must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		Was Decedent of H		pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	e, etc.
9200-61212	hours after tural', or ite	d by	3 Widowed 4 Divorced	Year or Dates: WW	11	1 ☐ Yes 2 🔀 No	Specify:		Specify: Whi	
7	within 72 ene. than "nat	plete	15. Decedent's E (Specify only highest gr	ade completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor d)	king	6b. Kind of Business/	ndustry
	e filed with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Facto	ory Worke			Western El	ectric
=	d be fill antal H (ed oth	Be	17. Father's Name (First, Middle, Las. Frank Keyes	1)		:		ne (First, Middle, M inette M	aiden Sumame) aconis	
С.	iges 1 and 2 should nt of Health and Men if Item 27 is marke or other treumatic	To	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street			City or Town, State, 2	ip Code)
	and 2 lealth a m 27 is		Annette Keyes -			Walther	Blvd. Ap		altimore,	
ō .	Pages 1 ament of Heamont: If Item		20a. Method of Disposition 1 Burial 2 Cremation 3	70	cemetery, crei	osition (Name of matory or other place Service C	orn 10/0		oc. Location - City or own	
baitim	E E E E		4 □ Donation 5 □ Other (Special Service Lice	nsee Charles Mi	ner 2	2. Name and Addre			Harford R	
מ	Depa Impo eny i		- CON VA		Le	eonard J.		nc. Balt	imore, Mar	yland 21214
Ġ	nysician /Medical		23a. Part1. Enter the disease, r com shock, or heart failure. Livi only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons		ter the mode of dyin	ig, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
ı	Examiner	_	Sequentially list conditions.	· Coronary	1 arte	ry disc	ease			
	ansit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence of):	•			,	
,00	be executed icien and burial-transit		resulting in death) Last	Due to (or as a cons	equence of):					
-	0 0 0	dlcal		d						
Š .	n certif	In/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		75			23d. Date of deli	very
ם כ	to the hospital or Attending Priysicien: The law requires that the death certificate be executed thinh 24 hours elder death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time o		Ectopic pregnancy Other (specify)			Month	Day Year
Ļ	s mar indication in the state of the state o	by Ph	Part II. Dther significant conditions				en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
cords,	een sig	ted !	Ena stage rena	failure on	hemod	ialysis, (Hrial	1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Sunknown
ב ב	he law hesb ge2st	Completed	Fibrillation, pace	emaker, parki	nsons d	isease, h	ypertens!	24a. Was an autopsy perform	prior to c	copsy findings available ompletion of cause of
ָם ד <u>ַ</u>	tificete	0	25. Was case referred to medical				26 Place of Dea		✓No 1 ☐ Yes	2 No
>	nysici his cer I direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Othe	200	16-1-19-1	nce 6 Other (Spec	ıfy)
	After ti	ton:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl		28d. Describe how	v injury occurred	
	Attended of death of the py the	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At	home, farm, str		Yes 2 □ No	28f. Location (Stre	eet and Number or Ru	ral Route Number,
בֿ בֿ	re of the or red Dir			building, etc. (Spe				City or Town.		
3	to the properied of steading Prysicient. The law within 24 burs efter death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2.	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exar	nysician: To the best of my k ninar: On the basis of exami and manner stated.	nowledge, death nation and/or in	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
4	within To the	₩	29b. Signature and title of certifler	and manner states.		29c. License			d. Date signed (Month	, Day, Year)
	6		> Lyzk			Dot	164408		10/6/08	
1	1)	1	30. Name and address of person who	completed cause of death (It	em 23a) (Type,		Iara D	rivo 2	nito MAN	01727
	Sta	_	31. Date filed (Month, Day, Year)	32. Aggistrar's Sig	nature	711130	nu e P	1110	MILL , MD	NEUI
1	Registra	ar	00T + 0 2	IIIK A	F0 82	MARS D				

			For State Ragistrar	ate of Maryland / Dep <i>Ce</i>	artment of H rtificate of L			2006	31949
	Physic		1. Decedent's Name (First, Middle, Last) Mary J. Leary				2. Date of Death Month D	ay Year	3. Time of Death 10.20 PM
	/Medi Examir		4a. Fecility Name (If not institution, give street BOHMORE WaShing H	11 1 1 1	4b. City, Town, or	Burnie		c. County of Death Ame Am	indef
	Funeral Director		5. Social Security Number 6. Sex 0 1 □ M 2 1	7. Age (In yrs. last birthday) 81 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 05/08/19	9. Birthpl Count	ece (State or Foreign ND MD
	Maryland -1 show	tor	10a. State 10b. County MD Anne Arund	el Odenton	ocation		*	10	ld. Inside City Limits 1¥ Yes 2 □ No
	h with the 23a or 28e st be not	al Director	10e. Street and Number 704 Chapel View D	rive	10f. Zip Code 21113		10g. C	itizen of What Count	ry?
9036	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "natural", or tieme 23a or 28e-1 show avant. The Mysilcal Expaning must be notified at	by Funeral	1 Never Married 2 Married 1	Yes 2 TNo	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 1 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e SpecifyWhit	tc.
Baltimore, Maryland 21215-0036	filed within 72 ho Hygiene other then "netu ent. Itte Medical	Completed	15. Decedent's Education (Specify only highest grade com, Elementary/Secondary (0-12) 1 2	oleted) (Give life.	dent's Usual Occupa kind of work done d DO NOT use retired) nistrat	luring most of worki 	Co	Kind of Business/Ind unty Mun Service	•
yland	should be file and Mental Hy smarkad oth umatic avant	To Be (17. Father's Name (First, Middle, Last) L. Clair Johns				(First, Middle, Maide or B. Ch		
Man	12 sh h and 7 is m traum		19a Informant's Name/Relationship (Type, Pr Mark J. Leary /	Son 234	Burns C	rossing	Route Number, City Road, Se	or Town, State, Zip (evern, M	D 21144
imore	Se to L		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo al from State McKean Mei	osition (Name of matory or other place MOPIAL PAI	rk 10/1		ocation - City or Tov Afayette,	
Balt	permit. Page Department i important: if any injury or once.		21. Signature of Funeral Service Licensee	\sim	Name and Address harles 501 Eas	s of Facility L · Sever t Fort	ns Funel Avenue,	Home In	c. e, MD 212
	death certificate be executed Ex Water and a strenging physicien and a for use as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	se on each line.			CAL CAR		Approximate interval Between Onset and Death
Box 6	death certifii e attending p d for use as	by Physician/Medical	in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date of deliver Month	y Day Year
Δ.	puires that n signed b lid be deta	d by Pł	Part II. Other significant conditions contribution	ng to death but not resulting in the u	nderlying cause giver	n in Part I.	23e. Did tobacco	use contribute to the	
	vicien: The law requires that the certificate has been signed by th rector, page 2 should be detache	Completed					24a. Was an autopsy performed?	death?	sy findings available pletion of cause of
ō	G w &	atlon; To Be	2 Accident investigation	I: 1 Inpatient 2 ER/Outpatien Date of Injury (Month, Day Year) ER/Outpatien	nt 3 DOA Other	4 Nursing Hon	(Check only one) ne 5 Residence (8d. Describe how inju		
É	in Diffe	Certification;	4 Homicide	. Place of Injury - At home, farm, str building, etc. (Specify)			8f. Location (Street a City or Town, Stat	e)	
	To the Hospitei within 24 hours a To the Funeral I completely filled	Medical	one) 2 Medical Examiner: Or	To the best of my knowledge death in the basis of examination and/or in dimanner stated.	vestigation, in my opi	s, date and place, a inion, death occurre	nd due to the eduso(s d at the time, date an) and manner as sta d place, and due to t	he cause(s)
)	To To Com	2	29b. Signature apprinted of certifier	mo		number	00	ate signed (Month, D	6 2006
	1		30. Name and address of person who complete	LI HELDHAIL &	Print)	in Gu	me n	0 00	6.
	Sta Registr		31. Date filed (Month: Pak Ydar) 2006	Registrar's Signature	afi.				

State of Maryland / Department of Health and Mental Hygiene () () 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year October 2, 2006 Lawrence В. Lewis 4:21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yung) Min. Jan. 20, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Virginia **Funeral** 7. Age (In yrs. last birthday) Year) 1₹ M 2∏ F 61 Yrs. Director 227-56-0577 1945 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 is marked other then "natural", or items 23a or 28a-f show troumatic event, the Medical Examities rount be notified at Director 1 ☐ Yes 2 No Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3417 25th Avenue 20748 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 (X) Yes 2 □ No1 965 If Yes, Give Year or Dates: 1967 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖺 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ring most of working al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fi and Menta William S. Lewis ဥ Ethel A. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other treum once. Chalmers McIlwain 3417 25th Ave., Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Veterans Cem. 10/10/06 Cheltenham, MD 22. Name and Address of Facility A.L. Bennett Funeral Home, Inc. 21. Signature of Funeral Service Licensee 515 Princess Anne St., Fredericksburg, VA 22401 Monne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 13 /Medical Due to (or as a consequence of): Examiner J 0 Sequentially litt conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Du o (or as a consequence of): the burial-transit To the Mospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-trar Due to (or as a consequence of): by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached fo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2.2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To 1. Inpatient 2 ER/Outpatient 3 DOA To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1-Natural 5 Pending Injury death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4467 Old Branch Ave. Suite 201 Bahram Redjaee, M.D. Temple Hills, MD 20748 31. Date filed (Month, Day, Year)

State Registrar

OCT 1 0 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		•	1 - State Amend item#24a, p	State of Marylan perMedical Record	d / Depai s,0860 Cert	tment of H IO/IO/06 T ificate of I	lealth and i Death		ene g. No. 2006	31951
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	'ee				2. Date of Death Month	2 - 2006	3. Time of Death 4 * /3 PM
	Examir		4a. Facility Name (If not institution, give : Genesis Randalisto)	on 9109 Liberte	y Road	Ran	Location of Death	w, MD	4c. County of Death	none County
	Funeral Director		227 30 3120	7. Age (In yrs.) 7. Age (In yrs.) 7. Age (In yrs.)		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12-23	9. Birtl 3–1948	nplace (State or Foreign untry) Md •
	Maryland f ahow	tor	Usuel Residence of Decedent 10a. State 10b. County Md . NA	10c. Cit	y, Town or Loca Balt	ation				10d. Inside City Limits 1 √2 Yes 2 □ No
	3a or 28a	i Director	10e. Street and Number 1005 E. Belvedere	e Avenue		10f. Zip Code 21212		10	g. Citizen of What Co USA	untry?
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "naturel", or Items 23s or 28s-f ahow any figury or other traumatic avent. Its Modical Exartic arminal be notified at ance.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Vivorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 🖔 No If Yes. Give Year or Dates:	lf '	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (S) an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: Bla	e, etc.
21215-0036	d within 72 ho piene. r then *natur ir e Medical	Completed by	15. Decadent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give ki	nt's Usual Occupa ind of work done of O NOT use retired	during most of wor	king	6b. Kind of Business/	ndustry
	td be files ental Hyg ked othe ic avent,	To Be C	12th grade 17. Father's Name (First, Middle, Last) Richard	Car	roll		18. Mother's Nam Kathy	ne (First, Middle, M	aiden Sumame) ernice	Teacher
Maryland	d 2 shou h and M 7 is mar traumat		19a. Informant's Name/Relationship (Ty	_	1-1				City or Town, State, 2 allstown, 1	
Baltimore, I	Peges 1 and ent of Healt of Healt of Healt of Healt of: If Item 2 by or other		Patricia A. Danie 20a. Method of Disposition 1 Burial 2 Cremation 3	emoval from State	lace of Disposi	tion (Name of atory or other place	(9)		Oc. Location - City or Baltimore	Town, State
Baltii	permit. F Departmo Importar any injur		21. Signature of Fundal Service License		22.	Name and Addres	ss of Facility	March F.1	H. East	21202
Ş	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deather cause on each line. Human J Due to (or as a consequence)	mmur	the mode of dying and spirit	-	or respiratory arres	st,	Approximate Interval Between Onset and Death
8760,	physicien and physicien and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq Due to (or as a conseq			- y	•		
.O. Box 68	The law requires that the death certifica tie hes been signed by the ettending ph tage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Fete 4 Pregnant at time of d	Ideath 3∏E	ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year
Q	quires thet n signed by	þ	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the unc	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
of Vital Records,		Completed						24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
Z Z	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Tes 2 The	lospital: 1 🗀 Inpatient 2 🗀	ER/Outpatient	3□ DOA Othe		th <i>Check only one</i> ome 5 ☐ Residen	nce 6 Other (Spec	ufv)
ion of	ding h. After fune	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. injun Work	/ at	28d. Describe how		,
Division	s after death s after death st Director; ad in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stree	et, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or At within 24 hours after d to the Funerel Direct completely filled in by	edical	29a. Certifier (Cneck only one) 1 Certifying Physical Examile (Cneck only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death of the tion and/or investigation	occurred at the time estigation, in my op	ne, date and place pinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier.	Sland		29c. License		1/4 29	d. Date signed (Month	n, Day, Year)
0	47		30. Name in Indiress of terson who co	impleted callse of death (Item 160 9109	1 23a) (Type, P	rint) Hy Roa	ed, Ra	ndallsto	wn, MC	2006
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 0 20	32. Régistrar's Signa	St. Lo.	mes!				

06-07378 Howard Lang

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	F	- For State Certificate of Death		eg. No. 200	6 3105
Physician Medical Examine		Decedent's Name (First, Middle,Last) Howard Lang	2. Date of Dea Month October 1		1211 hrs
Torse .		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center Baltimore City		4c. County of Deatl	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	8. Date of Bi	N/A rth(MM/DD/YYYY) 9. Bir	
Director		219-88-2579 1XM 2F 31 Yrs. Months Days Hours Min		Foreig	
auò		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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or 28a-	Director	10e. Street and Number 10f. Zip Code 4401 Necker Avenue 21236	1	0g. Citizen of What Cou	,
death with the Maryland or items 23a or 28a-f show any must be notified at once.	┋┝	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 14. Never Married 2 Married 2 Armed Forces? If Yes, specify Cuban, Mexican, Puerto			can Indian, Black,
ម ៦៧		1 K Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	Rican, etc.)	White, etc.	White
iours af	<u> </u>	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of volume and occupation (Give kind occupation (G	work done	16b. Kind of Business/	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Re Completed Hy Eurogral Disortor	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 11 Years Handy man	irea)	Top Notc	h Handy man
Baltimore, MD 21215-0036 remit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than njury or other traumatic event, the Medica		17. Father's Name (First, Middle, Last) Howard F. Lang	e (First, Middle, I	Maiden Surname)	
2121 uld be fill Mental B marked r event,		Wanda : 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	L. Brow		Zip Code)
MD and 2 sho thith and m 27 is aumati	L	Mr. Michael Lang (Brother) 4401 Necker Ave. 1	Notting	ham, MD 21	236
Ore, ges lar tof Hee . If itel	1	2Ca Method of Disposition 2 Cb. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
Baltim permit. Pa Departmen Important injury or o		4 Donation 5 Other Specify: Hilltop Service Corp 10, 21 Signature of Funeral Service In see			aryland
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Division of Vital Records, P.O. E tal or Attending Physician: The law requires that the cirs after death. al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached artification: To Be Commileted by Physicians	2	communing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to	
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Division o Rospital or Attending 49 hours after death. Funeral Director: After filled in by the fune ely filled in by the fune		4 Homicide determined (Specify) Found: residence	Dundalk,	tate) 7828 East	Collington Dr
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans Medical Certification: To Be Completed by Physician/Medical Expension	100	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at	due to the caus	e(s) and manner as start and place, and due to the	ed e cause(s)
To Too	2	and manner stated. 29c. License number		29d. Date signed (Mor	
		O.C.M.E.		October 2, 2006	
0	3	 Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212 	201		
State Registra	_	11. Date filed YMG TO Day, Year 2006 32. egistrar's Signatu			

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey Year **Physician** MARY L. MORGAN OCT 02 2006 16:16 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 9. Birthplece (Stete or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Months 1 □ M 2 🛛 F MARYLAND 212-32-5083 70 Director 06/08/1936 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Meryland Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐XYes 2 ☐ No N/A BALTIMORE CITY Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 2811 INDIANA AVENUE 21230 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BALTIMORE CITY Elementary/Secondary (0-12) 1 2 College (1-4or 5+) TEACHER'S AIDE PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LOUIS JOHNSON, MARGARET DIGGS 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2811 INDIANA AVE, BALTIMORE, MD 21230 LINWOOD MORGAN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 10/9/06 CATONSVILLE, MD 22. Name and Address of Facility 21. Signature of Euneral Service Licenses HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequ Physician/Medical Examiner ettending physicien and if for use es the buriel-trensit The lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease of Filmy that initiated events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be deteched 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed hes 1 Yes 2 NoN 1 ☐ Yes certificate or Attending Physician: : After this certifice e funerel director, r 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Maturel 1 Yes 2 No efter deeth. 2 Accident heral Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (*pecify) 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end manner es steted.

| Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner state. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tifle 29c. License number cause of death (Item 23e) (Type, Print)

State Registrar 32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31954 1 - For State Registrar Certificate of Death Reg. No. First, Middle, Las 2. Date of Death 3. Time of Death **Physician** /Medical stitution, giv 4b. City Examiner W If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs, last birthday) ce (StatePor Foreign Days Min. 1 12 M 2□ F Director Usual Residence of Decedent with the Maryland County 10c. City, Jown or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Examplement out the traumatic event, the Medical Examplement of the traumatic event. Director 1 Yes 2 No 10e. 10f. Zip Code 10g. Citizen of What Country? 0 death 1 Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Heelth and Mental Hygiene. Important: If flem 27 is marked other than "natural" ~ item any injury or other traumatic even. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White? etg 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(bive kind of work done during most of working files DO NOT use retired). 15. Decedent's Education Kind of Business/Industry only highest grade completed) 10 College (1-4or 5+) dary (0-12) Dair. 18. Morhor s Name (First, Middle Be Print) 19b Mailing Address (Street and Nu 20m Place of Disposition a. Method of Disno City or 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatu uneral Service Licenses ame and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as/a consequence of): Examine sate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 2 🗆 No 1 Yes 2 **N**O 1 🗌 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 2 No 2 1 🗌 Yes 1 Inpatient 4 🗌 Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) To the massive after death.

To the Funerel Director: After this 28a. Oate of Injury (Month, Day Year, 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner systed. 29a. Certifier Medical 29b. Signature and title of certified of death (Item 23a) (Type, Print) un 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Juli

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State of Maryland / Department of Health and Mental Hygiene 0 06 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Mary Angela Mattoni October 4:40 A M 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4h City Town or Location of Death 4c. County of Death Franklin Woods Nursing Center Baltimore. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) March 19, 1913 Birthplace (State or Foreign Country) **Funeral** 1 M 2 7 F Months Days Hours Min. 219-74-1585 93 Yrs Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "netural", or Items 23a or 28a-f ehow eny injury or other treumatic event, the Medical Examinar must be notified an once. 10a State 10h County 10c. City Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maruland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6305 Fieldvale Road 21237 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specity: White 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 9 Own Home. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Angelo Baccala Michele D'Adamo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Miklewski 6305 Fieldvale Road, Baltimore, MD 21237 (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State | Burial 2 | Cremation 3 | Removal from State | Commetery, Crematory or other place) | 4 | Donation 5 Nother (Specify) Entombment | Most Holy Redeemer Maus. 10/9/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a: Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each trie. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician O Man 19 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or inju-that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): ettending physic for use as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 25 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 | Pending after death. investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) 10 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) Rahnama 9512 Harford Rd ute 4 Bolto, UD 21234 32. Abgistrar's Signature 31. Date filed (Month, Day, Year) OCT 1 0 2006 Sports Registrar

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Quantile RES 000 (0-6-2006) 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Gauran Khanna RES 000 (0-6-2006) Boultimuse MD 21239	Divis	tel or Atters safter der el Directo	Certiflo	de te este	ad 286. Place of Inju	ury - At home, farm c. <i>(Specity)</i>	n, street, facto	ory, office		28f. Location (City or To	Street and Num wn, State)	ber or Rural	Route Number,
Quantile RES 000 (0-6-2006) 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Gauran Khanna RES 000 (0-6-2006) Boultimuse MD 21239		the Hospi nin 24 hou. the Funer npletely fill.	edical	one)	taminer. On the basis of	examination and/	or investigation	on, in my apii	nion, death occu	, and due to the rred at the time,	date and place,	and due to t	he cause(s)
GAUYAW Khanna (Item 23a) (Type, Print) Government Saman for Hospital Baltimum, MD 21239		To To	2	29b. Signature and title of certifier	MD		2						
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		le				eath (Item 23a) (Ty	/pe, Print)	,		man ta			
				31. Date filed (Month, Day, Year)		ar's Signature	Constant			VUYC , N	VID AC		

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			1 - For State Registrar	State of Mai	ryland /	Departme Certifica	ent of Hea ate of De	ilth and I ath		giene2006	31957
	Physici	an	1. Decedent's Name (First, Middle, Las			. 1			2. Date of Dea Month		3. Time of Death
	/Medic	cal	Leota M		Dar				oct	7 200	
4	Examir	ier	4a. Facility Name (If not institution, give	Maryland Maryland	Medical		ry, Town, or Loc		000	4c. County of Dea	th
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last b	irthday) If Und		Under 24 Hrs.	8. Date of Birth (Month, Day	N/A h 9. Bir	thplace (State or Foreign
	Director		217 74 0182	□м 2√2 г 47		Yrs. Month	s Days H	ours Min.	Month, Day	YS ICISO ME	ryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c City Toy	n or Location					10d. Inside City Limits
	Maryli febo	Į.	MD Baltimon			llawn					1 🗆 Yes 2 🔁 No
	r 28a-	Funeral Director	10e. Street and Number				Zip Code			10g. Citizen of What C	ountry?
	th with	aiD	5404 Clifton Ave.				21207			USA	
	Items Items	ıner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was De		nic Origin? (S	pecify Yes or No- o Rican, etc.)		
36	or li	by Fu	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give	•		200	pecify:		Specify: Wh	
21215-0036	within 72 hours after deeth with the Maryland ene. than "naturel", or items 23s or 28s-f ehow than dical Examinar must be notified at	edt	15. Decedent's Ed	Year or Dates:	168	a. Decedent's U	sual Occupation			16b. Kind of Business	
215	no 7	Completed	(Specify only highest gra				vork done durin		king		
21	DEL	Con	11			ashier	-			Groce	ry
ğu	S E D S	Be	17. Father's Name (First, Middle, Last)							Maiden Sumame)	
Maryland	should that Ment	ဥ	Gardner David Smo		10	h Mailina Addre			Mae Rabb	r, City or Town, State,	7- O-4-)
Z S	01 00 -		Michael McDaniel			404 Cli			odlawn,		Lip Code)
Baltimore,			20a. Method of Disposition			of Disposition (A		I	Date	20c. Location - City or	Town, State
Ē	Pages nent of ant: If it ant: or o		1 Burial 2 □ Cremation 3 □ Comparison 5 □ Other (Specify					ry 10/	11/2006	Ellicott C	itv. MD
Salt	permit. Page Department of Important: If eny Injury or ance.		21. Signature of Funeral Service Licen	see M	01442	22. Name	and Address of	Facility Ha	rry H. W	itzke's Fa	mily FH Inc.
	0 □ 2 • 0		23a. Part 1. Enter the disease, or comp	Sadder						icott City	
	Physician		Immediate Cause (Final disease or condition	a HCOAT	ocell		Carc			631,	Approximate Interval Between Onset and Death Months
	/Medical Examiner		resulting in death)	Due to (or as a	consequence						
		er	Sequentially list conditions. If any, leading to immediate	b. Due to (or as a	consequence	of):					
1	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		·						
oʻ	en an en an irial-tr	Exa	resulting in death) Last	Due to (or as a	consequence	of):					
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	dicai		d							
9 ×	ding p	/Med	IF FEMALE:	23c. If yes, outcome of	nregnancy						
Вох	death certificate attending plates as t	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at tir	Fetal deat	n 3 ☐Ectopic 5 ☐ Other (pregnancy specify)			23d. Date of de Month	Day Year
P.O.	oy th	Physician/Me	9 Unknown	9□ Unknown			, , , , , , , , , , , , , , , , , , , ,				
_	w requires that s been signed i should be det	þ	Part II. Other significant conditions of	entributing to death but	not resulting	in the underlying	cause given in	Part I.		bacco use contribute to es 2 □ No 3 □ Pi	
ဝ၁	lawre as ber 2 sho	Completed							24a. Was a	an 24b. Were at	utopsy findings available completion of cause of
æ	: The law cate has b , page 2 sl	Con							perfor		
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			104		th (Check only or		
5		7.	1 Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of Injury		utpatient 3 1		☐ Nursing H		ence 6 Other (Spe	cify)
Ö	Attending r death.	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y		Injury M	28c. Injury at Work?	2 🗆 No		and any obtained	
Vis	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	/ - At home, f.	arm, street, facto	ory, office		28f. Location (Si City or Town	treet and Number or Re	ural Route Number,
	ital or A			W							
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier (Check only one) Certifying Physics Certifying Ph	ysician: To the best of e inar: On the basis of e and manner state	xamination at	e, death occurre nd/or investigation	ed at the time, da on, in my opinion	ate and place, n, death occur	and due to the c red at the time, d	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	2000	7	2	9c. License nun	mber	_	9d. Date signed (Mont	
	1		JAN UZILLIU	icoc, m	レ		PI	854	5	october '	+,2006
	6		30. Name and address of person who de Angela Kope	ack 22	2 Sou	oth G	reene	st.	Baltim	are mD	21201
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1. 0 2008	2. Registrar's	s Signature	Specke					

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		Redistrar	Certificate of D			eg. No. 200	6 319
Physicia dical Examin		1. Decedent's Name (First, Middle,Last) Joel	Morris		2. Date of Dear Month October 3		3. Time of Death 1809 hrs
1		4a. Facility Name (if not institution, give street and number) 606 Washington Boulevard	4b.	City, Town, or Location of		4c. County of Death	
Funeral					r 24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bir	thplace (State or
Director			1 Yrs.	Months Days Hours	Min. 8–18	-1975 Foreig	untry) Md.
any		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Location				10d. Inside City Lim
daryland 28a-f show any datonce.	٥	Md. NA	Baltimor	e			1 X Yes 2
Maryl r 28a-1	Director	10e. Street and Number	10	f. Zip Code	1	0g. Citizen of What Cou	ntry?
Rer death with the Maryland "" or items 23a or 28a-f sho er must be notified at once.		606 Washington Boulevard 11. Marital Status 12. Was Decedent Ever	in IIS 13 Was D	21230 ecedent of Hispanic Original	oin? (Specify Voc or No	USA	inn Indian Black
leath w	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X	If Yes,	specify Cuban, Mexican,		White, etc.	ican Indian, Black,
after or	by F	3 Widowed 4 X Divorced If Yes, Give Year	1 Ye	s 2X No specify:		Specify: Bla	ck
hours		15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)	ed) 16a. Decedent's l during most	Isual Occupation (Give I of working life, DO NOT		16b. Kind of Business/	ndustry
)36 thin 72 than than edical	Completed	12th grade 4 Yrs.	Syst	em Eng.		System S	ource
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last)		18.Mother	's Name (First, Middle, I		-
2127 Ild be f Mental narked event,	o Be	Eugene Mo 19a. Informant's Name/Relationship (Type, Print)	rris, Sr.	Joa		Wells Ther, City or Town, State	Zin Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		Joan Morris Mother		Woodbourne			21239
re, I		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	20b. Place of Disposition crematory or other		Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ite		4 Donation 5 Other Specify:	Arbutus M		10-6-06	Arbutus,	Md.
Balt permit. Depart Impor		21. Signature of Funeral Service Licensee		and Address of Facility	riat CII	F.H. East	
Physician	Н	23a. Part I. Enter the disease, or complications that caused the d	death. Do not enter the n	L E. North lode of dying, such as ca	Ave., Balt. ardiac or respiratory arm	imore, Md. est, shock, or heart	21202 Approximate Inte
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a, End Stage Renal Di	isease				Between Onset a Death
LAdillile		or condition resulting in death) Due to (or as a consequent	nce of):				
	ř	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)	nce of):				
	aminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequer	nce of):				
cuted ind transit	EX	d					
760, ficate be executed g physician and the burial - transit	Medical	UNPENDED AMENDED					
8760, tificate be ng physicias the buri		IF FEMALE: 23c. If yes, outcome of 1 Live birth	pregnancy 2 Fetal of	eath 3 Ectopic	pregnancy	23d. Date of delivery	/ Day Year
. Box 687 the death certific y the attending property the for use as the	sician	past 12 months? 4 Pregnant at time 1 Yes 2 No 9 Unknown	of doub	(Specify)			,
by the ached faced f	Phy	Part II. Other significant conditions contributing to death but	not resulting in the unde	rlying cause given in Pa	rt I. 23e. Did to	bacco use contribute to	the cause of death?
ords, P.O. w requires that the sbeen signed by t should be detache	d b				1 Yes	2 No 3 Prot	pably 4 🗸 Unknov
Records, The law require ificate has been si r, page 2 should b	Completed				24a. Was autop		topsy findings availa
tal Keco cian: The law certificate has ector, page 2 s	mo				perfor		_
VITAI KEC ysician: The l his certificate l director, page	Bec	25. Was case referred to medical examiner?		26.Place of Death (F		
1 Of VItal ling Physician After this certi funeral director	P	1 Yes 2 No	2 ER/Outpatient 3 28b. Time of Injur			Residence 6 Other	: Scene
On C on c ath. or: Af the fun	ţi	1 Natural 5 Pending (Month, Day, Year)		1 Yes 2		ion injury document	
DIVISION tal or Attendir s after death.	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury -	At home, farm, street, fa	ctory, office building, etc	c. 28f. Location (S or Town, S	Street and Number or Ru	ral Route Number, 0
spital hours a neral J		4 Homicide determined (Specify) 29a. Certifier					
LIVISION Of VITAL RECORDS, P.O. BOX 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Examiner: On the basis of examinati	-			• •	
To with	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Moi	nth, Day, Year)
		Carol Hall	an	O.C.M.E.		October 4, 2006	
567	İ	30. Name and address of person who completed cause of death	,	-1 D-10 -7=	04004		
20		Carol Allan, MD Assistant Medical Examine 31. Date filed (Month, Day, Year) 32. Registrar's Sig		et, Baltimore, MD	21201		
Sta Regist		OCT 1 0 2006		- N			
MH 17 Rev 1/20	001	and the same of th	ORIGINAL	SA			

06-0/340 llease Type or Print in Black Indelible Ink ryland / Department of Health and Mental giene Lori Morris State of 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day September 29, 2006 1833 hrs **Medical Examiner** Morris Lori 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Md. Good Samaritan Baltimore 5. Social Security Number 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Months Davs Hours Min Director Country) 220-72-6485 M 2XXF 3-4-1967 Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No notified at once. Baltimore Director Md NA 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 1620 Lyle Court 21234 USA Funeral 11. Marital Status 13 Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married 2 Married Yes 2 X No Specify: Black 3 Widowed 4 Divorced f Yes. Give Year Yes 2 X No specify Examiner þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Baltimore Co.Dept. Elementary/Secondary (0-12) College (1-4 or 5+) nt of Health and Mental Hygiene.

ott: If item 27 is marked other thau "
other traumatic event, the Medical I Pages 1 and 2 should be filed within 72 Appeals Unit 220-72-6485 of Sicial Services 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Preston Morris Irma Crockett ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby Cox-Redman 2206 Corbin Rd., Baltimore, Md. Sister Baltimore, Permit Pages I and Department of Healt Important: If item injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10-6-06 Md. Nat. Mem. Pk. Laurel, Md. Donation 5 Other Specify. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East Tray Milk 1101 E. North Avenue, Baltimore, Md 21202 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a, Pulmonary Thromboembolism due to left deep vein thrombosis Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UNPENDED AMENDED Livision of Vital Records, P.O. Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Obesity Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' 1 V Yes 1 ✓ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ٩ 1 🗸 Yes 27. Manner of Death 28a Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d Describe how injury occurred 28b. Time of Injury Certification 1 🗸 Natural Yes 2 No 5 Pending the 24 hours after death Funeral Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within 2 To the 1 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 30, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31 Date filed (Month, Day Year) State 0 2005 Registrar

			i lease i	State of Marylan		ent of Health an	•		,,,,,	
		1	For State Registrar	otate of Marylan	•	ate of Death	a mornarry	Reg. No. 0	16	31960
	ysicia		Decedent's Name (First, Middle, Last) Arleatha		Miles		2. Date of De Month		Year	3. Time of Death 12:14 A M
	Aedica amine		4a. Facility Name (If not institution, give st		1 4b. 0	ity, Town, or Location of E		4c. County	of Death	
			Franklin Squ 5. Social Security Number 6. Sex	T. Age (In) rs.	Ital I	hoseauc nder 1 Year if Under 24	Hrs. 8. Date of Bi	th ba		nore (State or Foreign
Fun Direc				M 2DXF 75	Yrs. Mont		Min. 8. Date of Bir (Month, Date 10-1	2-30	Coui	place (State or Foreign ntry) N.C.
and			Usual Residence of Decedent 10a. State 10b. County		ty, Town or Location					10d. Inside City Limits
Maryla	a kal	ţō	N.Y. NA		Brooklyn	n				1 X Yes 2 □ No
ith the or 288	te nat	Direc	10e. Street and Number		10f.	. Zip Code		10g. Citizen of V	Vhat Cou	ntry?
eath w	Tales.	eral	452 Empire Blvd.	2. Was Decedent Ever in U	I.S. 13. Was D	11225	? (Specify Yes or N			can Indian,
ING 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. d other then "naturel", or iteme 23e or 28e-f ehow	Examiner	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		ecedent of Hispanic Origin specify Cuban, Mexican, For 21 No Specify:	Puerto Rican, etc.)	Specify	k, White,	, etc. ack
5-0 72 ho	dical	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent's (Give kind o.	Usual Occupation f work done during most of T use retired)	f working	16b. Kind of Bu	siness/In	idustry
VIZ.	The Ma	dwo	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)	Labor	·		Variou	ıs	
		To Be C	17. Father's Name (First, Middle, Last) Thomas	Mi	iles	18. Mother's	Name (First, Middle ZZİE	e, Maiden Sumam Carra		
Tarylan 2 should be and Mental	other traumatic		19a. Informant's Name/Relationship (Typ	e, Print)		ress (Street and Number of				
~	2		Kim Gardner 20a. Method of Disposition	Daughter 206.1	365 Kos Place of Disposition cemetery, crematory	ciusko Stree	Date	yn, N.Y. 20c. Location -		221 Town, State
0 0 -	-		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, crematory t. Matthew		10-14-06	LaGran	ıge,	N.C.
Baltimo	y inju		21. Signature of Funeral Service License	0	22. Nam	e and Address of Facility	MARCH FU	NERAL HO	ME-E	AST
m goe	a a	-	23a. Part1. Enter the disease, or complic	rations that caused the dea	th. Do not enter the	1 E. North A	venue Bal	timore,		21202 Approximate
Physic /Med	lical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	ronary	Antery (Occlus			Interval Between Onset and Death
Exami	Y .	<u>.</u>	Sequentially list conditions, b.	Due to (or as a consec	alal I	ntarction	DV)			
petn	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Hypert	enslor)				
3760, ste be executed sysicien end	urial-tr	Exa	resulting in death) Last	Due to (or as a consec	quence of):					
6876 ificate b g physic	s the b	dical		¥						
O Lead	r use as	Physician/Med	230. Was decedent pregnant	3c. If yes, outcome of pregn		ic pregnancy		23d. Dat	te of deliv	very Day Year
P.O. B that the deatled by the atte	op ped fo	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of of 9☐ Unknown	death 5 Othe	r (specify)				
dS, P. Jires that the signed by	e deta	by Ph	Part II. Other significant conditions con	tributing to death but not re	sulting in the underlyi	ing cause given in Part I.	23e. Did	tobacco use conti	ribute to	the cause of death?
Cords wrequire been sig	plno	ted						Yes 2□No	3 Pro	bably 4 Onknown
Records, The law requires to the been signer	CA	Completed						opsy formed?/	prior to co death?	opsy findings available ompletion of cause of
Vital sician: Th certificate	tor, pa	Be Co	25. Was case reterred to medical	18		26. Place o	1 ☐ Yes if Death (Check only	7	∐ Yes	2□ No
of VI hysici nis cer	direc	To B	examiner? 1 Yes 2 No	ospital:	ER/Outpatient 3		ing Home 5 ☐ Res	sidence 6 Oth	er (Spec	ify)
Sing Pl	the funeral director, page		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		how injury occurr	ed	
2 4 5 8	in by the	Certification:	Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Speci	nome, farm, street, fa		28f. Location	(Street and Numb own, State)	er or Rur	al Route Number,
Hospita 4 hours Funersi	tely filled	Medical C		ician: To the best of my kn er: On the basis of examin						
To the wit in 2 To the	omple	Med	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signe	d (Month	, Day, Year)
	5		E all	li delle	MO	Res 000	00	10-7-	06	
5	•	5	30. Name and address of pers who co	leted cause of death (ite	m 23a) (Type, Print)	Square 1	X RAI	human	W	d 21237
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ALMA MARINA	TO LINE	, but	ICIAI NE	111	.4 0.001
Re	oistr.		DOT 1 0 201	16	H Bosel	29				

			1 - State Registrar	State of Maryla		epartment of F Certificate of		Mental Hy	giene Reg. N2 0 0	16 31961
	Physici	500	1. Decedent's Name (First, Middle, Las	MERRE	14			2. Date of Dea	ath Day/	Yeer S A M
	/Medic Examin		4a. Facility Name (If not institution, give Summ 1 ## Carl	street and number) KNUKS LRE	chab	Cato	DSUNI	<		imore
	Funeral Director		119-10-2609	PX 7. Age (In yr	-	nday) If Under 1 Year Months Days	If Under 24 Hr. Hours Min	. (Month, Da	y, Year)	Birthplace (State or Foreign Country) GA
	anyland ehow	7	Usuel Residence of Decedent 10a. State 10b. County		•	or Location				10d. Inside City Limits 1X Yes 2 □ No
	r 28a-f	Irecto	MD NA 10e. Street and Number	Be	11C1	more 10f. Zip Code	_		10g. Citizen of Wi	
	eath wit	Funeral Director	3913 Cedardale	Road 12. Was Decedent Ever in	11.5		1215	Specify Yes or No.	U • S	• A •
036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow ite Madical Exercites must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	0.3.	13. Was Decedent of Hif Yes, specify Cub.	Specify:	nto Rican, etc.)		Black
9500-612	"natur	leted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of we	orking	16b. Kind of Bus	iness/Industry
212	filed within Hygiene. Ither then ont, the M	Completed	12th grade	College (1-4or 5+) 3yrs		Nursing A	i de			d Pratt
Maryland	a a b y	To Be	17. Father's Name (First, Middle, Last) John Darby				18. Mother's Na Elzie	ame (First, Middle, Greir	Maiden Sumame	1)
lary	2 should and Men ie marke	-	19a. Informant's Name/Relationship (r 19b.	Mailing Address (Street				
	s 1 and if Health item 27 other to	l k	Marshall Strick 20a. Method of Disposition	206		00 Cedar Disposition (Name of or other pla		Dr, Cat		le, Md 21228 City or Town, State
altimore,			t ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	y)		id Ridge	10,	/11/06	Pikesv	ille, Md
Ba	permit. Page Depertment Important: If eny Injury or once.		21. Signature of Funeral Service Licer	larch		March F/	H West ash Ave	e, Balt:	imore,	Md 21215
			23a. Pert1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Me TAS Due to (or as a cons		TC LUN	16 0	ANCE	FR	
	Examiner	er	Sequentially list conditions, if any, leading to infinediate	b. Due to (or as a cons	ecuanea c	A):				
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8760,	ficate be executed physicien and is the burial-transit	dical Ex	resulting in death, cast	Due to (or as a cons	equence o	nt):				
Box 6	death certific e ettending p id for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred 1☐Live birth 2☐Fe		3 □Ectopic pregnanc	v			e of delivery
o.	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time o		5 Other (specify)			Mon	in Day Year
rds, P	sign Sign d be	þ	Part II. Other significant conditions of	ontributing to death but not r	esulting in	the underlying cause gr	ven in Part I.	23e. Did t	-	ibute to the cause of death? 3 Probably 4 Unknown
Records,		Completed						24a. Was autor perfo 1 Yes	psy pr pred? de	Vere autopsy findings available rior to completion of cause of eath?
Vita	hysiclan: The la nis certificate has I director, page 2	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpatient 2	□ER/Out	tpatient 3 DOA Oth		eath (Check only of		(Coopie)
n of	ding Phy h. After this funeral d	 -	27. Manner of Death	28a. Oate of Injury (Month, Day Year,	28b. T	ime of 28c. Inju	ry at	-	how injury occurre	
Division of Vital	deatl deatl ctor: y the	Certification;	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e ago Place of Injuny - A	t home, fai	M 1 ☐]Yes 2∐No	28f. Location (: City or To	Street and Numbe wn, State)	er or Rural Route Number,
	To the Hospital or A within 24 hours effer To the Funeral Direction completely filled in by	edical C	29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Example 1	nysician: To the best of my k niner: On the basis of exam and manner stated.	nowledge ination and	, death occurred at the tid/or investigation, in my	me, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and man date and place, a	ner as stated. Ind due to the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier	2 AR	-	29c. Licen:		1	. / 1	(Month, Day, Year)
1	N		30. Name and address of person who	completed cause of death (I	tem 23a) (Type, Print)	58/	× (CHOSE	4, 2006 21136
	`		31. Date filed (Month, Day, Year)	Street A	MARC	LO BOBM	o Key	, decotor	in Mid	21136
	St: Regist	ate rar	OCT 1	0 2006 Dases	a f	1. Spenter				

		•	State State Registrar	of Marylan		artment of H	lealth and M Death		giene eg. N2 0 0 6	31962
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	E. A	1AR	TIN		2. Date of Dea Month	Day Year	3. Time of Death
	Examin			SAPRAK		1	r Location of Death		4c. County of Death Anne A	perpol
	Funeral Director		5. Social Security Number 215−38−3738 0	7. Age (In yrs. 84	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day OCT 29	Year) 9. Birth Cou 1921 Penns	place (State or Foreign ortry) Sylvania
	Maryland -f ehow	tor	10a. State 10b. County Maryland Anne Arundel	10c. Cit	y, Town or Lo		nnapolis	-		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the 3s or 28s	i Direc	10e. Street and Number 727 Broadmoor Drive			10f. Zip Code	21409		10g. Citizen of What Cou USA	ntry?
980	hours after death with the Maryland turel', or Itama 23e or 28e-f ehow at Examinations be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Yes.	ecedent Ever in U Forces? is 2 X No Give r Dates:		Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 ☒ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
21215-0036	within 72 ene. than "nai	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	ed) e (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work d)	ing	16b. Kind of Business/Ir	dustry
Maryland 2	should be filed ind Mental Hygin marked other umatic avent, II	To Be C	17. Father's Name (First, Middle, Last) Martin Alfred Ruttk	ay		į		e (First, Middle, abeth A	Maiden Sumame) • Metz	
Man	12 sho h and 7 is m	1 2	19a. Informant's Name/Relationship (Type, Print) Glenn H. Martin, II/Son	n		,			r, City or Town, State, Zij 01 is, MD 21^2	ŕ
nore,	Pages 1 and nent of Healt ant: If Item 2 arry or other	15	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from the Disposition (Constitution)	ALI STATE		osition (Name of matory or other place	l l	Date	20c. Location - City or T	
Baltimore,	permit. Pag Department Important: I eny injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Edward A. Gregore		2:	2. Name and Addres	Inc. 10/9 ^{ss of Facility} Cr rick Road	emation	Baltimore, Society of more, MD 212	MD, Inc.
3760,2	The law requires that the death certificate be executed XX at the attending physicien and XX at a page 2 should be detached for use as the burial-transit at YX.	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consecto (or a) (or as a consecto (or a) (quence of).	DOMO	NTIA			Interval Between Onset and Death
O. Box 6	at the death certifica by the attending phi tached for use as th	Physiclan/Med	23b. Was decedent pregnant 1 Lin in the past 12 months? 1 Ves 2 No. 4 Pr	outcome of pregnate birth 2 Feta egnant at time of continuous	al death 3[□Ectopic pregnancy □ Other (specify)	/	ţ	23d. Date of deliving Month	ery Day Year
Δ.	equires that sen signed b tould be deta	2	Part II. Other significant conditions contributing t			_	en in Part I.		bacco use contribute to tes 2 \(\text{No} \) 3 \(\text{Pro} \)	he cause of death?
I Records,		Completed	DYSPHAGUA					24a. Was a autop perfor	sy prior to co	opsy findings available impletion of cause of
Vital	icien: certific rector,	Be	25. Was case referred to medical examiner?		1=0:0	. all so i Oth	26. Place of Davi			
of	Jing Afte fune	atlon: To	1 162 25 NO	☐ Inpatient 2☐ ate of Injury fonth, Day Year)	28b. Time of Injury	of 28c, Injur Wor	4 ursing Ho		ence 6 Other (Speci low injury occurred	fy)
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	ne Hospital 24 hours a ne Funeral	Medical	29a. Certifier (Check only one) Check only one)	the best of my kno e basis of examina nanner stated.	owledge, deal ation and/or in	th occurred at the tire exestigation, in my o	me, date and place, opinion, death occur	and due to the d red at the time, o	cause(s) and manner as a date and place, and due	stated. o the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	Len	no	29c. Licens			29d. Date signed (Month)	
	10	9	30. Name a address of person who completed of	ause of death (Iter	m 23a) (Type	Print)	en a Hi	Chho sa.	OCICION 8	1111
	Sta Regist		31. Date filed (Month, Day, Year) 3 OCT 1 () 2006	2 Registrar's Sign	ature.	AN ELOPE	rins 1716	xinnay.	rp weigi	ue MI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Sandye Jean McIntyre II October 8, 2006 3:00am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours September 1923 Arkansas 297-14-7310 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits N/A Maryland Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4900 Pilgrim Road 21214 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Types 2 No WWII Yes, Give Specify.Black 1 ☐ Yes 2 💢 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Professor Morgan State University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dr. Rev. Sandy John McIntyre Sr. Gladys Means 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Carleen S. Leggett/Companion 24 Primrose Court Parkville Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gardens 10/14/06 Timonium Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck Inc. 5305 Harford Road Baltimore Maryland 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal Diseage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? Yes 2 No 2 No 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

Examine physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. Physician/Medical been signed by the should be detached Certification: To Be Completed by s after dea... ral Director: Aftr

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

77 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, the once.

Physician /Medical

Examiner

25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No 27. Manner of Death

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

and manner stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LHOU 67 01 31. Date filed (Month, Day, Year)

OCT 1 0 2006



To the Hospital of within 24 hours aff To the Funeral Discompletely filled in

Medical

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Registrar

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DHMH 17 Rev 1/2001

Registrar

2006

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 20:39 M GENEVIEVE MOORE October 2006 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Memorial 7. Age (In yrs. last birthday) BALTO nion If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 2ØF Yrs. 215-28-6832 **Director** 2,1931 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other then "natural", or Items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 18 Yes 2 □ No **Funeral Director** MD SALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Rel 12. Was Decedent Ever in U.S. Armed Forces? 212 1040 filed within 72 hours after death Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cultan, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2 No fYes, Give rear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BLACK Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Processing TecH u Blic 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event ODEs. Be BerT Forrester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6242 The ALAMEDA BALTO. MD. 21239 MOORE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST 10-13-06 OWINGS MILLS MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility Fun Suc P.A. Michael 219 Tier Fun Suc P.A. 3312 Fre Berick Ave BAI BA140, MD, 21239 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dyschuthmia Physician Ventricular 20 min /Medical Due to (or as a consequence of): Examiner Vascular evebral Merith Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner eripheral Vascular Disease attending physicien and for use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed 10 yrs Due to or as a consequence of): Box 68760, ypertension 2045 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) vis certificate has been signed by the a director, page 2 should be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an performed? this certificate 200 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 3□ DOA Medical Certification: To 2 ER/Outpatient within 24 hours after death.

To the Funers! Director: After thi
completely filled in by the funers! 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT2438946 ause of death (Item 23a) (Type, Print) 30. Name and address of person who comp Robert McKinstr East University Parkway Baltimore MD 201 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 1 0 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}8,2006 **Physician** October 11:01 AM REGINA S. NOVOTNY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Parkville Baltimore Morningside House 7. Age (In yrs. last birthday)
O 2 Yrs.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. F CD 5 7 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** 7913 1 □ M 2**X**□ F 218-46-4009 Maryland Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or iteme 23e or 28e-f show empiriquery or other treumatic event, the Medical Exemination must be notified at ance. 10a, State 10c. City, Town or Location 10d. Inside City Limits Glen Arm Baltimore 1 Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13006 Dulaney Valley Road 21057 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Executive Secretary Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Smolinski Rose UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13006 Dulaney Valley Road-Glen Arm, MD 21057 19a. Informant's Name/Relationship (Type, Print) James L. Novotny-son Date 20c. Location - City or Town, State Holy Cross Polish National Cemetery 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility EVANS FUNERAL CHAPEL AND 8800 Harford Road CREMATION SLRVICES maral Parkville,MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician men Month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown signed i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 280 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 ☐ Could not be in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Suite 4 Baltimore, Maryland 21234 Mohammacl Rahvana 9412 HarFord 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 1 0 2006 Registrar

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			For State Registrar	State of Marytan		rtificate			2006	31967
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last) Aa. Facility Name (If not institution, give signs)	/\	Vei	ghot Jab. City, Tow	vn, or Location of I	'	Day Year	3. Time of Death
3	Funeral Director		5. Social Security Number 216-70-2623 Usual Residence of Decedent	7. Age (In yrs. 97	last birthday Yrs.) If Under 1 You Months Da		Hrs. 8. Date of Birth Min. (Month, Day, May 1, 1	Year) Cou	place (State or Foreign ntry) yland
	e-f show	ctor	10a. State 10b. County MD		y, Town or L Baltim					10d. Inside City Limits 1X Yes 2 No
	with the	Funeral Director	10e. Street and Number			10f. Zip Coo		10	g. Citizen of What Cou	ntry?
	eath ve 234	eral	3320 Benson Ave	nue 2. Was Decedent Ever in U	S 13		1229	2 (Specify Ves or No-	USA 14. Race - Amen	can Indian
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be multired at 90se.		11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify (n? (Specify Yes or No- Puerto Rican, etc.)	Black, White,	etc.
21215-0036	within 72 h ene. than "natu he Med cal	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	edent's Usual Oc e kind of work do DO NOT use re emaker	one durina most o	of working 1	6b. Kind of Business/Ir	ndustry
	filed Hygin other		17. Father's Name (First, Middle, Last)		110111	emaker	18. Mother's	s Name (First, Middle, M		
Maryland	Aental Aental rked o	To Be	William Bri	entenbach			Ca	atherine Do	rsch	
ary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mail	ing Address (Str		or Rural Route Number,		o Code)
	1 and 2 Health tem 27		Barbara Bernard	- Daughter				Baltimore, 1		
Baltimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 12☐8urial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, cre	osition (Name o	place)		Oc. Location - City or T	
텵	mit. Pag partment portant: y injury c		4 □Donation 5 □ Other (Specify) 21. Signa □ of F neral Service Licepse		don Pa	ark Ceme	ddress of Facility	0-11-2006 Ba	altimore, M	laryLand -Witzke
Ba	permit. Departr Importa		Deman)	Telsote	Fi	ineral F	Home of (Sterling-Asl Catonsville venue; Cator	Inc.	21220
	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the deat cause on each line.			dying, such as ca			Approximate Interval Between Onset and Death
4	/Medical Examiner	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of the consequence of t	0/05	tructi	ive pu	Umonar	y disease	Venrs Vears
8760, e	ate be executed hysician and the burial-transit	lical Examin	that inflated events resulting in death) Last	Due to (or as a conseq	uence of):	1 1 1 00	1 (, g	1 1 100 1 10		7 0000
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Vita	ician certific ector	Be	25. Was case referred to medicat examiner?	ospitat:			0.1	f Death Check only one		
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	To the Hospitel or A within 24 hours after To the Funeral Directionally filled in by	edical	(Check only 2 Medical Examin one)	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge, dea ition and/or ii	th occurred at the	ne time, date and my opinion, death	place, and due to the car occurred at the time, da	use(s) and manner as a te and place, and due t	stated. to the cause(s)
)	To t To t	₩.	29b. Signature and title of certifier	my,	MI	29c. Lie	cense number	91 0	d. Date signed (Month.	,2006
	\		30. Name and address of person who cor	npleted cause of death (Iter	n 23a) (Type	Print) NUC,	Baltin	nore Ma	ryland	21227
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 0 2001	32 Aegistrar's Signa	ature	medi			/	

			1 - For State Registrar	State of Ma	aryland /	Depa Cer	irtment of H <i>tificate of L</i>	ealth and M Death		^{ene} 2006	31968	
			Decedent's Name (First, Middle, Last) 2. Date of Death							3. Time of Death		
	Physici /Medic									11.15 A. M		
	Examin								4c. County of Death	and the second s		
	Funeral		5. Social Security Number		e (In yrs. last b	/	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	O Dieth	pplace (State or Foreign	
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	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits	
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Ext. citing rotals be notilised at angles.		MD Anne Arundel Laurel 1□Yes 2√2No									
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920		by F	3 ☐ Widowed 4 ☐ Divorced	ied 1 □ Yes 2 /2/2 If Yes, Give Year or Dates:	If Yes, Give		1 ☐ Yes X ☐ No Specify:			Specify: Wh	nite	
5-0		To Be Completed by	15. Deceden		16a. Decedent's Usual Occupation (Give kind of work done during most of wo			furing most of work		16b. Kind of Business/Industry Johns Hopkins Univ.		
121	within ane.		Elementary/Secondary (0-12)	(+)				U		A.P.L.		
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/lar			William Galyon					Dora Hall				
lan			19a. Informant's Name/Relations				•		al Route Number, (City or Town, State, Z.	ip Code)	
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Baltimore,	ages ant of at: if it		1 🕅 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		cemet	ery, cren	natory or other place	1		lkridge, M	·	
altir	permit. P Departme importan any injur		4 Donation 5 Other (Specify) Meadowridge Mem. Pk 10/11/2006 Elkridge, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Donaldson Funeral Home, P.A.									
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18	Physician and /Medical Examiner supplies the private transit	ner	23a. Part 1. Entarthe disease, or shock, or heart failure. List	only one cause on each li	ne.					st,	Approximate Interval Between Onset and Death	
			Immediate Cause (Final disease or condition resulting in death)	a	PHIC	'ک	hoen	du	to			
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rds	quires n sigr uld be	ed by	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 U								obably 4 ⊠Unknown	
000	law requir as been si 2 should l	plet							24a. Was an autopsy	24b. Were aut	topsy findings available ompletion of cause of	
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Division of Vital Records,		Certification; To	1 ☐ Yes XX No 27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								
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ivis			3 Suicide 6 Could i 4 Homicide determ	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
_			29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
		edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To t To t	Σ							d. Date signed (Month			
,	15		1 /Ceyr	MD	la sala (18 22) (T	Doc	05-3707	TE A	10/6/0 (
	19		20. Name and address of person RAJ CHAW				Fox 1	ane s	TE A	210 1	wie MD	
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	Registr	ar	UCT 1	0 2006	er K		make p					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 8, 2006 **Physician** George H. Pappas 2:15 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Blakehurst Care Center Towson Baltimore 8. Date of Birth (Month, Day, Year) Jan. 17,1918 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Funeral Days 1√2 M 2□F Hours 213-16-2318 88 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Me. Ical Examiner must han account once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 W. Joppa Road Apt. 414 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces: 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: White Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Restauantuer/Businessman Food/Distribution 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry George Pappas ပ Kaliope Pistolas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise N. Pappas/ Wife 1055 W. Joppa Rd. Apt.414 Towson, Md. 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) Woodlawn Cemetery 10/10/06 Woodlawn, Maryland 21. Signature - Flury Sirvio 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc.Towson,Md. 21204 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Findisease or condition resulting in death) **Physician** Cardionnapath chumic weeks /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform After this certificate 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the discontinuous physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) October 9 2006 DYI and address of person who completed cause of death (Item 23a) (Type, Print) N. Challes ST Baronny and 21204 6565 Asron 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar		State of Ma	aryland		artment of H		and M	R	leg. No. Z U	06	31	970
	Physici /Medic		Decedent's Name (Fire Donald Wall)		•						2. Date of Dea Month	Day 9 2	Year 26	3. Time of 10:30	
1	Examin		4a. Facility Name (If not 864 W. 37					4b. City, Town, or		of Death	9	4c. County Balt		e City	
	Funeral Director		5. Social Security Number 106-20-152	er 6. Se	7. Ag	e (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 11/2	5 ⁷ 7 ⁴ 928	9. Birthp NY	lace (State o try)	r Foreign
	aryland show	_	Usual Residence of Deci 10a. State 10b MD	. County	ore City		, Town or Lo						1	0d. Inside Ci	
	or 28a-f	Directo	10e. Street and Number			Ба		10f. Zip Code 21211				10g. Citizen of V	What Cour		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Important: If item 27 is marked other then "netural", or Items 23a or 28a-f ehow apprignty or other traumatic event. Ite Modical Examinar must be nutilised at ODGE.	by Funeral Director	864 W. 37 11. Marital Status 1 Never Married 3 Widowed 4	2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If If Yes, Give		1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛛 No	lispanic Ori an, Mexican Specify:	gin? (Spe i, Puerto f	city Yes or No- Rican, etc.)	14. Rac Blac	e - Americ ck, White, /: Whi	etc.	
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	he Hospi in 24 hour he Funer pletely fill	edical			ysicien: To the best niner: On the basis o and manner st	f examina		vestigation, in my o	pinion, dea		ed at the time,	date and place.	and due to	the cause(s	5)
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City City	Sta Regist		31. Date filed (Month, D	OCT 1 0	2006 32. Registr	rar's Signa	ture	Goarle)		r					

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Matthew R. Powell		- For State	St	ate o	f Maryla		epartment Certificate			d Me	ental Hy		leg No.	21	00	6 3	197
Physician/		le gistrar 1 Decedent's Nam	e (First, Midd	e,Last)							- 2	2. Date of Dea	ath			3. Time of Dea	ath
Medical Examine	r	Matthe	w Ric	hard	l Pow	e11						Month October 3	3, 2006	Year		1556 hrs	
	•	4a. Facility Name (street and nu	mber)			City, Town, or arrettsville		on of Death			County of arford	Death		
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Funeral Director	П	5. Social Security N		6. Sex			yrs. last birthday)		Months Day	_		A	1	006		place (State of Washin; ntry) D	
Birector		215-13-76 Usual Residence o		1 X N	И 2F	- 4	20	rs.				Aug. 2	29, 1	986	Cou	ntry) D.	ن.
any	-	10a. State	10b. County			10c.	City, Town or Lo-	cation								10d Inside Cit	y Limits
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filled within 72 hours after death wi Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatte event, the Medical Examiner must be To Be Completed by Funera	1	19a Informant's Na Richard				r	1	_	ddress (Stre lunt Cr				_			21084 21084	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit certification: To Re Completed by Physician/Medical Expedical Certification: To Re Completed by Physician/Medical Expedical Certification:	3	X UNPENDED)		AMENDED	item#	23a,27,28a	-f :	nerME os	260	10/12/0	6 TT		-			
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Sox death death of a steer for us		1 Yes 2	No 9 Un	known	9 Unkn		ordeath 5	Other	(Specify)								
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To the within 2 To the complet		29b. Signature and			and manner	stated			29c. Licer							th, Day, Year)	
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Registra	Ш		UUI J	y L		Mall griss	- Par P	7		-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Darryl 07:22AM Poole 30 /Medical 2006 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Mem. Hospital Baltimore NA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1 X M 2 □ F 219-72-6880 Director 47 1-21-1959 Md. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral 2527 E. Chase Street 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced Specify. Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) llth grade Disabled NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William ျှ Poole, Jr. Henrietta Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other trau Norma J. Griffin Cousin 3810 The Alameda, Baltimore, Md. 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Cem. 10-7-06 Dundalk, Md. permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EN MIN March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Zomin morena ue to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last 0 Examiner Due to (or as a conser ence of) al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Monknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 W Natural 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours aft

To the Funeral D

completely filled is Fo the Hospital Example 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. non Memoral 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12-00 P.M Delia Octobes 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkens 6. Sox Cety Hospital Baltimore Johns 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. flate of Birth (Month, Day, Year) April 9,1950 Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🖸 F Yrs. Director 215-76-6595 56 Korea Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits "neturel", or iteme 23a or 28e-f ehow 1 ☐ Yes 2 XNo Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10166 Breconshire Road 21042 U.S.A. Pages 1 and 2 should be filed within 72 hours after death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Korean Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Business Owner Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I Unknown Fuechun Noe ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Depertment of Health ar Importent: If item 27 leeny Injury or other traconce. 10166 Breconshire Road Ellicott City, MD 21042 Sung Soo Pak (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Memorial Pk 10-7-2006 | Marriottsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardia. Arrest /Medical Due to (or as a consequence of): Examiner Myperkalemia
Due to (ordas a consequence of): hrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itilated events resulting in death) Last Examiner physicien and s the burial-transit Renal 12 hrs Failue Due to (or as a consequence of) Box 68760 Physician/Medical adenied cystic Carcinana IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۾ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 Yes 2 X/No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death tlon: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours efter death. investigation Certificat 2 Accident within 24 hours efter deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Octobes Bhawna Gupta Medical Doctor Res - 000 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Street, Bathmore Maryland 2128 & Bhanna Gupta Johns Hopkins Herrital

32. Registrar's Signature The ASSILLE 31. Date filed (Month Pay Year) 2006 State Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 31974

		Registrar	or Death		eg. No.									
Physicia	an/	Decedent's Name (First, Middle, Last)	-	Date of Deat Month		Time of Death								
ledical Exami	ner	Brittany Danielle Phenicie		Month October 4	, 2006	0826 hrs								
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death									
		Howard County General Hospital	Columbia		Howard									
				lo para ef Ba		/0/								
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min.	-	th(MM/DD/YYYY) 9. Birth Foreign									
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	ŀ	Usual Residence of Decedent												
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		Ml . Beautell de D	O.C.M.E.		October 5, 2006									
		of una received, M. Co.												
	l l	30 Name and address of person who completed cause of death (Item 23a)	1 Pann Street Baltimore MD	21201										
		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
			r Ferrir Street, Baltimore, WD											
S Regis		31. Date filed (Month, Day, Year) OCT 1 0 2006 ASSISTANT Medical Examiner 11	Perin Street, Baltimore, MD											

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	Examin	er	Southern Maryland		•		- 7.	into		, Douit				orge's
	Funeral		5. Social Security Number 6. Sex	7. A		last birthday)	If Under	1 Year	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da		9. Birth	place (State or Foreign
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Maryland	d 2 should th and Men 17 is marke traumatic	Ċ	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	g Address	(Street a	and Numbe	r or Rura	l Route Numbe	er, City or Town,	State, Zip	Code)
	of Health Item 27 other tr		Deatrea L. Wilt/Da	ughter)r., (WV 25		
Baltimore,	Pages 1 nent of H int: If ite iry or ot	3	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F	emoval from State	206. P	lace of Dispo emetery, cren Lence	sition (Nari patory or of Care	ne of ther place	9)		ate	20c. Location -		own, State
	it. Pa rtmen rtant: njury		4 Denation 5 Other (Specify)	200		atomica	a 1		1	0/16		Aurora, are, 20		7 37 nd
ga	permit. Pages of Department of Himportant: If ite any Injury or ot any Injury or ot angles.		21. Sign ture of Juneral Service Licens	Volta	-							CO 800		2. J2III
		-	23a. Part1. Enter the disease, or compli	cations that cause	ed the death									Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final			1 at		1			81.1.	N icen.	4	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or a	s a consequ	uence of):	pe	nigin	lany	VA	200100	Disean	-	
	Examiner		Sequentially list conditions	Sap	sis									
	# #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequ	uence of):								
k	be executed icien and burial-transit	хат	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequ	ience of):	<u> </u>							
,09/	δ <u>ς</u> δ	calE			o a concoq.	30,100 017.								
_	ficate p phys is the									-				
X R OX	deeth certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcom			Ter					23d. Dat	te of deliv	өгу
מ	of the deeth by the atte	slcla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant a 9□Unknown			Ectopic pro Other (sp					Мо	nth	Day Year
٦ 5	et the	Phys	9 Unknown											
Š,	w requires thet been signed b should be deta	by	Part II. Other significant conditions cor	tributing to death	but not resi	ulting in the ur	nderlying ca	ause give	en in Part I.		***	_		he cause of death?
Vital Records,	neen s	Completed									LAC.			bably 4 ∐Unknown
ec E	has be 2	dm									24a. Was autop	sy r		opsy findings available emptetion of cause of
e e		e Co	25. Was case referred to medical								1 Yes	21 No 1	I □ Yes	2 □ No
	Physician: this certific ral director.	To Be	examiner?	lospital:	ient 2□	ER/Outpatien	t 3□ DO	A Othe			Check only o	<i>ne</i> dence 6 ⊟Oth	er (Sneci	60
	ig Phy ter thi		27. Manner of Death	28a. Date of In	urv	28b. Time of		Bc. Injury Work				now injury occurr		
0	를 돈 잘 들	atlo	1 Natural 5 Pending 2 Accident investigation	(, -	_,	,u.y	М		Yes 2 □	No				
		Certification:	3 Suicide 6 Could not be determined	28e. Place of Ir building, e	njury - At ho	ome, farm, str	eet, factory	, office			28f. Location (S City or Tox		er or Rura	al Route Number,
_	Hospital of Hours at Funeral Ditely filled i		On Continue 1 Minute in Physics	delen T. d. L.	A - 1 · 1									
	Mospital or 24 hours afte Funeral Dir letely filled in	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami											
	To the Mithin 24 To the F complete	Me	29b. Signature and title of certifier				29c	. License	number			29d. Date signed	1 (Month,	Day, Year)
			> Wellin 1 a	men				D3	3520	Ç		OCTUR	シマ	. 2,06
	2	1	30. Name and address of person who co	mpleted cause of	death (Item	23а) (Туре,	Print)	,	-	1	7 1			,
	<i>U</i> `			Anna A	n	1701	Livin	Eltu	n Ki	אלי	port w	ASH ING &	n n	who we
	Sta Registr		31. Date filed (Month, Day, Year) 200	5 Hegis	uars Signa	A A A	uti)							Day, Year) , Zwb

Certificate of Death

3. Time of Death

Reg. No

2. Date of Death

1. Decedent's Name (First, Middle, Last)

Month Day Physician James October 4, 2006 5:40 P Ryan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Howard Columbia If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 12 M 2□ F Months Days 132-22-0453 April 19,1929 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo Clinton Town of Plattsburgh 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 28 Newell Avenue 12901 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M2 Yes 2 □ No 1947— If Yes, Give Year or Dates: 1967 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ⊠ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Data Processor Educational Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James J. Ryan Helen Clukey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Ryan/Son 28 Newell Avenue, Plattsburgh, NY 12901 20b. Place of Disposition (Name of cometery, crematory or other place)
St. Mary's of the Lake Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 10/09/06 4 ☐ Dopation 5 ☐ Other (Specify) Plattsburgh, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brown Funeral Home, Inc. 29 Broad St., Plattsburgh, NY Dennes mur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART DISEASE 15CHEMIC YEARS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACZHE(MELL'S D(SEASE) 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performes 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۵ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation within 24 hours after death. To the Funerel Director: A 1 Tes 2 No in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide completely filled Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signarule and title of certifier 29d. Date signed (Mgnth, Day, Year) 027394 N. CALVERT ST #325 BALTO. NO 21218 RICHARDSON MY MAMES 3333 32. Ragistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1_ State	tate of Maryland /	•	artment <i>tificate</i>			ind M		giene Reg. Na2 ()	n s	310	77
			Registrar 1. Decedent's Name (First, Middle, Last)			incate	OIL	Cairi		2. Date of De		00	3. Time of	Death
	Physici			Clair Morrell	Rov	vell				Month Octobe	er 6, 2	Year	3:10	P^{M}
Spec	/Medic Examin		4a. Facility Name (If not institution, give street	t and number)		4b. City, T	Fown, or	Location of	f Death		4c. Cour	nty of Death		
			9160-M Hitching Pos	st Lane		Laure	e 1				Howa	rd		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b		If Under 1 Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da	y, Year)	Cour	lace (State or	Foreign
L	Director		Usual Residence of Decedent	71	Yrs.					Apr 28	, 1935	Geor	gia	
	land		10a. State 10b. County	10c. City, To	wn or Lo	cation	-					1	0d. Inside Cit	y Limits
	Mary -f sh	tor	MD Howard	Laure	21								1 ☐ Yes	2 🕅 No
	r 28e	Director	10e. Street and Number			10f. Zip (Code				10g. Citizen o	of What Cour	ntry?	
	23e o	ai D	9160-M Hitching Pos	st Lane		207	723				U.S.A.			
	ams frain	Funeral	11. Marital Status	Vas Decedent Ever in U.S. Armed Forces?	13. V	Was Decede	ent of His	spanic Orig	jin? (Spe	cify Yes or No		ace - Americ		
36	hours after death with the Maryland tural', or Itams 23e or 28e-f show at Examinat must be multified at	by Fu	1 ☐ Never Married 2 X Married	XYes 2 No		I □ Yes 2		Specify:		, ,	Spec	cify:		
5-0036	hours tural'	q pe	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education	rear or Dates: 1952-56		ient's Usual	I Oggung	tion			16b. Kind of	Whit		
5	filed within 72 h I Hygiene. othar than "netu	Completed	(Specify only highest grade co	mpleted)	(Give	kind of work	k done di e retired)	uring most	of workir	9	100. Kind of	Dusinessynn	uustiy	
2121	s with	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Compu	iter S	Speci	lalis	t		Depart	ment o	of Defe	ense
73	be filed within 72 hours after death with the Marylan Ital Hygiene. Id othar than "netural", or Itams 23e or 28e-f show event, the Medical Examilier must be notified at	Be C	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle,	Maiden Sum	ame)		
<u>a</u>	ould be Mental arked o	To	Henry L. Driggers					Mary	L. 1	Melton	****			
Maryland	2 she and is m		19a. Informant's Name/Relationship (Type,							Route Numbe				
<u>6</u>	l and lealth im 27 her ti		Eileen Cunningham I	Rowell/spouse 9				ng Po		ane, La	urel,			
altimore,	toff fita		1 X Burial 2 ☐ Cremation 3 ☐ Remo	val from State cemet	ery, cren	natory`or otl	her place	1						
	it. Printmer		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee,	Maryl	-	Veter Name and				11, 06	Crowns	ville	, Maryı	.and
Ba	permit. Pages 1 and 2 should be f Department of Health and Mental b Important: if itam 27 is marked of any injury or other traumatic eve once.		1 1/4/15	M00773	_ [E	onalo	ison	Fune:	ral 1	Home, Paurel,		nd 205	707-139	20
			23a. Part1. Enter the disease, or complication	ons that caused the death. Do				_				110 20	Approximate Interval Betw	
6	Pnysician		shock, or hear failure. List only one ca Immediate Cause (Final disease or condition	Adenocarcinom	na of	the	nanc	reac				7.	Onset and D	eath
	/Medical		resulting in death)	Due to (or as a consequence		CIIC	pane	LCUB					VCCRB	
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ď	be fix	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):									
k	and and II-tran	хап	that initiated events resulting in death) Last	Due to (or as a consequence	e of):							-		
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Õ	ificate g phy as the	edic	u											
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	ed for	sicia	1 Yes 2 No	Pregnant at time of death		Other (spe					P	vionth	Day Y	ear
о. О	res that the de signed by the a be detached f	Physician/Me	9 ☐ Unknown Part II. Other significant conditions contributions		in the contract			- i- O I		220 Didte	obacco use co	atabuta ta th	an source of de	nath?
Š	ires the signed to be d	l by	COPD	ming to death but not resulting	i si uie ui	idenying ca	inze čivei	n in Pait I.			res 2□No		ably 4 🗆 U	
Records,	w require been si	Completed	Hypertension								- 4			
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Vital	(g) 14		25. Was case referred to medical					26 Place	of Dogsth	1 Yes	2 🔯 No	1 🗆 Yes	2No	
	Physician: this certific ral director,	o Be	examiner? 1 ☐ Yes 2 🔀 No	ital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatien	t 3 DO	A Other	-		ne 5 X Resid		ther (Specifi	v)	
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jo	Attanding ir death. ector: After by the fune	atic	2 Accident investigation		,,	М		es 2 🗆 N	No					
Division of	l or Attano after death Director: I in by the	Certification;	3 Suicide 6 Could not be determined 2	Be. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory,	office		2	8f. Location (5 City or Tox	Street and Nui vn, State)	mber or Rura	l Route Numb	ner,
	urs af urs af aral D		an out of the state of the stat											
	Hosi 24 ho Funs stely f	edicai	29a. Certifier 1 A Certifying Physicia (Check only one) 2 Medical Examiner:	n: To the best of my knowled; On the basis of examination a and manner stated.	ge, death and/or inv	occurred a restigation,	in my opi	e, date and inion, deat	n piace, a h occurre	nd due to the	cause(s) and i date and place	manner as si e, and due to	tated. the cause(s)	
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier	2 2 2		29c.	License	number			29d. Date sign	ned (Month,	Day, Year)	
1	-> 0		Monnie.	& Dohn-		T)2	90	73		101	9 bo	26	
	641		30. Name and address of person who compl	eted cause of death (Item 23a) (Type,	Print)		- (-()			1100	01	
1	J .		Marie A. Dobyns, M.			n Roa	d, L	aurel	L, Ma	ryland	20707			
	Sta Registr		31. Date filed (Month Pay, Year) 2006	32 registrar's Signature		aces 1								
	negisti	ur	7	provident for										

		For State	State o	f Marylan	d / Depa	rtment of	Health	and M		ene 00	6 319	378
		Registrar 1. Decedent's Name (First, Middi	a last)	·	001	incate o	Dean	,	2 Date of Death	g. No.	3. Time	of Death
Physicia	an	VALENTINE		REME	ivis			ŀ	Month OCT,	Day Y		5 P M
/Medic		4a. Facility Name (If not institution			1///3	4b. City, Town	or Location	of Death	001,	4c. County of		
Examin	er	Genesis Eld			Raven		Parkv				ltimore	۵
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I		If Under 1 Yea	ar If Unde		8. Date of Birth		. Birthplace (State	or Foreign
Director		216-28-5668	1 ∑ M 2□ F	85	Yrs.	Months Day	's Hours	Min.	8. Date of Birth (Month, Day, Aug. 30	7921	Lithuani	ia
р.		Usual Residence of Decedent										
how	_	10a. State 10b. County		10c. City	, Town or Lo						10d. Inside	City Limits as 2 X No
the Marylan r 28e-f ehow notitied at	5		altimore			Baltimo						2 5 140
h with th	al Director	10e. Street and Number 9203 Hines Roa	ad			10f. Zip Code	21234		10	ng. Citizen of Wh. US		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f ehow eny injury or other treumetic event. The Medical Examinar must be notified at ORCE.	by Funeral	11. Marital Status 1 ☐ Never Married 2▼ Mar 3 ☐ Widowed 4 ☐ Divorced	ried Armed Fo	2. /Š No ∕e	I	Vas Decedent o Yes, specify C			ecify Yes or No- Rican, etc.)	Black,	American Indian, White, etc. White	
ithin 72 ho ne. nen "natur	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5+)	(Give I life. E	ent's Usual Occ kind of work doi OO NOT use reti Tailor	ne durina mo	ost of worki	ng	16b. Kind of Busin	•	
iled w tygier ther th		12 17. Father's Name (First, Middle,	(ast)				18 Mot	her's Name	(First Middle A	faiden Sumame)		
uld be f Mental P irked of	To Be	John Remeik					[Andreki	-		
id 2 should Ith and Men 27 is marke treumetic		19a. Informant's Name/Relations Douglas Remeik			1 3					City or Town, St.		
Pages 1 and nent of Health out: If item 27 ury or other to		20a. Method of Disposition 1	3 □Removal from	State Pa	lace of Dispos	sition (Name of patory or other p Cemete			ate 2	20c. Location - Ci	ty or Town, State e, Maryla	nd
permit. I Departm Importer eny inju		21. Signature of Funeral Service		10/10	8	Name and Add 800 Har Parkvil	ford F	ility EVA	NS FUNE	RAL CHAP	PEL AND TION SER	VICES
12/5		23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that conly one cause on	aused the death ach line.	Do not ente	er the mode of o	IE, ML) lying, such a	21234 s cardiac o	respiratory arre	est,	Approximately Ap	etween
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	aDue to	On SS onsequ	J7V-(ME	CVI	-/	ailui	re		
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	led											
The law requires that the death certific ate has been signed by the atlending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live b	tcome of pregna birth 2 Fetal nant at time of de own	death 3	Ectopic pregnal Other (specify)				23d. Date of Month	,	Year
res that igned b be deta	by Pi	Part II. Other significant conditi	ons contributing to d	eath but not resu	ulting in the ur	iderlying cause	given in Parl	t I.	23e. Did tob	acco use contrib	ute to the cause of	death?
quire n sig uld b	p p								1 🗌 Ye	s 2□No 3	☐ Probably 4	Unknown
	Completed								24a. Was ar autops perform 1 Yes 2	y prid ged? dea	ere autopsy finding or to completion of ath? 1 Yes 2 2 No	s available cause of
icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						ce of Death	(Check only one	9)		
hysio	မ	1 ☐ Yes 2 X No			ER/Outpatien	3 DOA		-		nce 6 Other		
Ing P	on:	27. Manner of Death 1 Natural 5 □ Pendi	'9	of Injury th, Day Year)	28b. Time of Injury	V	ijury at Vork?		28d. Describe ho	w injury occurred	I	
tendi leath. tor: A the fu	catl	2 Accident invest 3 ☐ Suicide 6 ☐ Could	gation not be				Yes 2		701 1 1 10		0 10 11	
s after c	Certification:	4 ☐ Homicide determ	ningd 288, Place	of Injury - At ho ing, etc. <i>(Specif</i>)	me, rarm, stre	eet, ractory, offic	28		City or Town		or Rural Route Nu	mber,
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, to	Medical	(Check only 2 Medical one)		e best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the estigation, in m	time, date a y opinion, de	and place, a	and due to the ca ed at the time, da	use(s) and mannate and place, and	er as stated. d due to the cause	+(s)
To t with. To t	Σ	29b. Signature and tyle of certifie	Atton	em 1	1 Kys	29c. Lice	ense number	73	642 (Od. Date signed (Month, Day, Year)	06
10		30. Name and address of person	va 67	0/ N	cho	Print)	st.	421	R Bo	Atim.	ne 2/2	204
Sta Registr		31. Date filed (Month, Day, Year OCT 1	2006	egistrar's Signa	ture	ente						
			15.		9							

			For State			State o	of Maryla		partme ertifica				Mental Hy	. 9	006	319	279
			1. Decedent's Name	(First, Middle	e, Last)				Ortino	110 01	Dour		2. Date of De	Rag. No	000	3. Time o	f Death
	Physici				H	arry J	oseph	RiggI	eman				Septe	Day	28.2		450
	/Medic Examin		4a. Facility Name (If	not institution						ty, Town, o	r Location	of Death	БСРСС		ounty of Dea		100
				Memor	rial	Hos					East				Γalbo	t	
	Funeral		5. Social Security Nu		6. Sex/	M 2□F	7. Age (In yi	rs. last birthd	Month	der 1 Year ns Days	Hours Hours	Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Bi	rthplace (State o Country)	or Foreign
	Director		579.74.5 Usual Residence of I					49 Yrs					January	/ 27, 19 5	57	MD	
	ryland how		10a. State	10b. County			10c.	City, Town o	Location							10d. Inside C	•
	e Ma	Director	Maryland	(Queen	Annes				(Center	ville				1. Yes	2 🗌 No
	with th	Dire	10e. Street and Num						10f.	Zip Code				10g. Citize	en of What C	,	
	deeth with the Maryland me 23a or 28a-f ehow r must be notified at	erai	101 N. Lit	berty St.;		2 Was Dec	edent Ever in	118	3 Was De	cedent of H		1617	ecify Ves or N	0- 14		J.S.A. lerican Indian,	
(0	5 ± 2	Funeral	1 Never Marrie	ed 2 Mari		Armed Fo	rces? 2 🗌 No			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	an, Mexica	an, Puerto	ecify Yes or No Rican, etc.)		Black, Wh		
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d 2	Hygie Hygie Sther	Co	17. Father's Name (F	12 First, Middle,	Last)						18. Moth		e (First, Middle	, Maiden S	umame)	-	
erry Riggleman Baltimore, Maryland 21215-0036	rmit. Pages 1 and 2 should be filed within 72 hours after deeth with the Manylan partment of Health and Mental Hygiane. portant: if Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show y injury or other traumatic event, the Madical Examinar must be multiped at	To Be		Ken	neth F	Rigglem	an							Betty	Baer		
ary	and N		19a. Informant's Nar	me/Relations	hip (Type	e, Print)		19b. M	ailing Addre	ess (Street	and Numl	ber or Aur	al Route Numb			Zip Code)	
002	and 2 m 27 I		Mr. Nicho		leman	1	Son				oud Co		ton, Maryl				
ore R	t of H t of H f iter		20a. Method of Dispo 1 ☐ Burial 2 🖁		3 ∐Rei	moval from		. Place of Di cemetery,	sposition (for trematory of	lame of or other place	сө)		Date	20c. Loca	ation - City o	r Town, State	
r H	permit. Page Department Important:		4 Donation				Mr. Star	В	ayview				/30/2006		Baltii	more, MD	
	E od mi		21. Signature of Fun	leral Service	Censee	R	14412	13	22. Name	and Addre	Euner	al Hom	e PA				
Ξ.			23a. Part1. Em the shock, or heart	e diseres, o	complica	ations that d	aused the de	ath. Do not	enter the m	-00644	310 to0	HIMBBIA	Pike Ellica	ott City,	MD 210	Approximal	te
	Physician		Immediate Cause (F	Final	only one	cause on e	each line.	1	MAN	100	1-1	00-	0.			Interval Bet Onset and	ween Death
	/Medical		disease or condition resulting in death)		a.	Due to	or assocons	equence of):	10110	ear	6	i i	X125				
	Examiner		Sequentially list con-	ditions.	b. 5	enc	& Star	ge	Rex	101	1	vilo	1				
_	SE / BE	iner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or in	mediate lying	Į	Due to	(or as a cons	quence of):	,								
	end end al-tran	Examiner	that initiated events resulting in death) La		C.,	Sel.	(or as a cons	equence of):	am	9						-	
5 8760	cate be executed physicien end the burial-transit	dicai E				(100	agul	0 00	they								
့် ဖွ		edic			u.				0								
Sox S	The law requires that the death certific ate has been signed by tha attending p page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent		230		tcome of prec		3 □Ectopic	pregnancy	,			23	d. Date of de		.,
₹.	that the death ed by tha atte detached for	sici	in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nontns?] No			nant at time o		5 Other						Month	Day	Year
P. G.	hat th ad by detach	Phy	Part II. Other signific	cant conditie	ons contr	ributing to d	eath but not r	esulting in th	e underlyin	n cause div	en in Part	1	23e. Did	tobacco use	contribute	to the cause of o	death?
ds,	uires tha signed id be dei	d by	End	Sto	100	1	VP	Sri	lun	,				Yes 2 ☑	_	Probably 4 🔲	
Second Record	w requir been si should	iete	Horut	生;	2	-1	200	- 1					24a. Was	an	24b. Were a	utopsy findings	available
~ B	fhe lav te has age 2 :	ошо	1	12		-	7		\					ormed?	death?	utopsy findings completion of c	ause of
پر Vital	ician: Th certificate ector, pag	BeC	25. Was case referre	ed to medical	\sim						26. Plac	ce of Deat	1 ☐ Yes	one)	1 1 10	\$ 2 NO	
) > 50	hysic his ce I direc	ToE	examiner? 1 Tes 2 1	No	Но	spital: 1 🗗	Inpatient 2	☐ ER/Outpa	tient 3	DOA Oth	er: 4 🗆 N	lursing Ho	me 5□Res	idence 6	□Other (Sp	ecify)	
	Attending Physician: r death. ector: After this certifica by the funeral director, i		27. Manner of Death 1 ☑ Natural	5 Pendin	ig	28a. Date (Mon	of Injury th, Day Year)	28b. Tim Inju	y	28c. Injur Wor			28d. Describe	how injury	occurred		
Division	ttend death stor: /	cat	2 Accident 3 Suicide	investi 6 ☐ Could	not be	200 Place	of Injury - At	home farm	M street feet		Yes 2	JNo	28f Location	Street and	Numberor	Rural Route Num	nhor
	after Direct	Certification:	4 Homicide	determ	ined	buildi	ing, etc. (Spe	cify)	Street, lact	ory, onice			City or To	wn, State)	Number of F	iorar noole ivun	iber,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier	1 Certifyir	g Physic	cian: To the	best of my k	nowledge, d	ath occurr	ed at the tin	ne, date a	ind place,	and due to the	cause(s) a	nd manner a	is stated.	
	To the He within 24 To the Fu	Medicai	one)			er: On the b and man	asis of exami ner stated.	nation and/o	rinvestigati	on, in my o	pinion, de	ath occur	red at the time,			e to the cause(s	<u>;)</u>
	To To To To To To To To To To To To To T	2	29b. Signature and t	itle of certifie			1		-	29c. Licens	e number	17		29d. Date	signed (Mor	nth, Day, Year)	
			1000	W		Eur	11	1		<i>レラ</i> 。	176	1		9/2	8/6	16	
	17		30. Name and addre	ss of person	who com	npleted caus	se of death (It	em 23a) (Ty	pe, Print)	201	200						
	Sta	te	31. Date filed (Month	h, Day, Year)	- 0/	32 F	Registrar's Sig	nature		- ' '	17/1/						
	Registr	ar	0.0	CT 0 6	2006	1	Salard .	B. A.	geoff	1							

State Registrar 29b. Signature/and title of certif

31. Date filed (Month, Day,

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32. Registrar's Signature

29c. License number

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 9. Carol Ann Rams Oct. 6:00 A M 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,)
Dec. 13, Funeral 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🏲 F Months Days Hours Min Year Director 220-40-9382 61 Dec. 1944 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be i 1550 Nicodemus Road 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Be Completed by 3 Novidowed 4 Divorced Specify: white white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home permit, Pages 1 and 2 should be filed Department of Health and Mental Hygii important; If Item 27 is marked other any Injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wallace Mauck Gladys Wollet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley M. Barley - Sister 1550 Nicodemus Road Reisterstown, MD 21136 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Oct. 10, 06 Baltimore City 4 Donation 5 Dother (Specify) ²² Name and Address of Facility
Cremation Society of Maryland, Inc. 21. Signature of Funeral Service 299 Frederick Road Baltimore, MD 21228 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cancer montas disease or condition resulting in death) /Medical Due to (or a a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter the conditions of the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed At hours after death.

Funeral Director: After this certificate has been signed by the attending physician and easily filled in by the funeral director, page 2 should be detached for use as the bunat-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Sfue ို 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 ☑ Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OC TORCA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Granne no 21204 6161 31. Date filed (Month, Day, Year) 32. Redistrar's Signature 2006 Registrar 0

06-07055 Joseph Schriefer

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar	Certificate		Re	eg No. 2006	3198
Physicia Medical Examiñ		1. Decedent's Name (First, Middle, Last)	Schrief	EE	2. Date of Deat Month Septembe		Time of Death 0905 hrs
		4a. Facility Name (if not institution, give street	and number)	4b. City, Town, or Lo		4c. County of Death	
-/ <u>-</u>		Maryland Correctional Institution 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Jessup	If Under 24Hrs. 8. Date of Birt	Anne Arundel	place (State or
Funeral Director	,		70	Months Days	Hours Min. 7-10	Foreign	ntry) MD
ow any	Ī	10a. State 10b. County	10c. City, Town or Lor Ball		,		0d Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show any notified at once.	Director	10e. Street and Number		10f. Zip Code	. [10	Og Citizen of What Countr	
ith tl	eral Di		as Decedent Ever in U.S. 13.1	Was Decedent of Hispa	anic Origin? (Specify Yes or No-		an Indian, Black,
	by Funeral	3 Widowed 4 Divorced If Yes, or Date	Yes 2 No Sive Year s. 1	Yes 2 No	·	White, etc.	nite _
6 72 hours in "natur	Completed	15. Decedent's Education (Specify only high Elementary/Secondary (0-12) Co	llege (1-4 or 5+)	dent's Usual Occupation most of working life. D	n (Give kind of work done O NOT use retired)	16b. Kind of Business/Inc	dustry
-0036 I within 72 giene her than	E	17. Father's Name (First, Middle, Last)	ukn	18	Mother's Name (First, Middle, M	UKn Maiden Surname)	
D 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than antire event, the Medicanatic	<u></u>	Victor Schri	efer	(arol Fy	2	
MD 2: hould all hand M m 27 is m. aumatic e	ဥ	19a. Informant's Name/Relationship (Type, Pr C3ROL Ravenceo	at 25	17 N N	Nader of Rural Route Nu		Zip Code)
Nore, MC ages Land 2 s nt of Health ar t: If item 27 other traums		20a Method of Disposition 1 Burial 2 Cremation 3 Rer	noval from State crematory or	oosition (Name of ceme other place)	tery, Date	Balto W	own, State
Baltimore, permit Pages I an Department of He Important; If ite	Ì	4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee	22	2. Name and Address of	Facility //// PAC 13	Mettagelit	
Physician /Medical	1	23a. Part I. Enter the disease, or complication failure. List only one cause on each line.	s that caused the death. Do not ente		ich as cardiac or respiratøry arre	74.00	Approximate Interval Between Onset and
Examiner	Ì		croin intoxication (or as a consequence of):				Death
	Ę.		(or as a consequence of):				
n is	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(or as a consequence of):				
evecu lan and	Medical E	ddAME	NDED : 150mH220 27 200	of porME age	10/11/06 TT		<u>-</u>
76 icat	_	IF FEMALE: 23c. 23c. 1	item#23a,27,28a If yes, outcome of pregnancy Live birth		Ectopic pregnancy	23d. Date of delivery Month Da	y Year
	sicia	past 12 months? 1 Yes 2 No 9 Unknown 9	Bressest at time of death	Fetal death 3 Other (Specify)	coppo pregnancy	INORIT DA	y real
, P.O. Be rees that the designed by the	by Phys	Part II. Other significant conditions contrib	outing to death but not resulting in th	e underlying cause give		bacco use contribute to the	Parent
Division of Vital Records, P.O. na or Attending Physician: The law requires that the rs after death an Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed		-		24a. Was a	an 24b. Were auto	psy findings available impletion of cause of
Vital Records, ysician: The law requir his certificate has been selector, page 2 should	E Comp				perfor 1 ✓ Yes 2	med? death?	2 No
'ital sician: is certil	Be	25 Was case referred to medical examiner?	1 Inpatient 2 ER/Outpatie	.0	f Death (Check only one)	Residence 6 🗸 Other: S	Scene
n of V ding Phy After th	옵 ::	. —	a Date of Injury (Month, Day, Year)			low injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Sion vitendi death ctor:	atio	Z Accident investigation	Find 9/18/2006 Find 8:	<u> </u>	s 2 X No unknown		
Division Division ours after death teral Director: filled in by the	Certification:	Suicide b X Could not be	e. Place of Injury - At home, farm, st Specify) correctional	institution	ding, etc 28f. Location (S or Town, Si Instituti	treet and Number or Rura tate) Mary Land Cor Lon Jessup, MD	Route Number, City rectional
DIVISION To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the	the best of my knowledge, death oc basis of examination and/or investi-				
7. wi	We	29b. Signature and title of certifier	anner stated	29c License r		29d. Date signed (Month	
rid	-	30. Name and address of person who complet	ed cause of death (Item 23a)	O.C.M.	E.	September 19, 200	Jb
1000		Ana Rubio MD. Assistant Med	dical Examiner 111 Penn	Street, Baltimore	e, MD 21201		
Sta Registr		31. Date filed (Month, Day Year) 0 2006	32. Redistrar's Signature	gaste			

06-07546 Helen S Silk

Please Type or Print in Black Indelible Ink

TEIETI S SIIK		For State State of Maryland / Department of Health and Menta Certificate of Death egistrar		eg. No. 200	6 3198:
Physician/ Medical Examine	1	Decedent's Name (First, Middle,Last) Helen Margaret Silk	Date of Deat Month October 6		3. Time of Death 2148 hrs
	4	la. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Rosedale		4c. County of Deat Baltimore Cou	
Funeral Director		5. Social Security Number 212-36-1330 6. Sex 1 7. Age (In yrs. last birthday) 6. Months Days Hours		th(MM/DD/YYYY) 9. Bi 21, 1937 Cc	
м апу	-	Journal Residence of Decedent	 ir		10d. Inside City Limits 1 Yes 2X No
the Maryland a or 28a-f show any tified at once. Director	1	Oe. Street and Number 10f. Zip Code	11	Og Citizen of What Cou	
or death with the	1 1	1601 Martha Court, Unit 301 21015 1. Marital Status 1. Never Married 2. Married 2. Married 2. Married 2. Married 2. Married 2. Married 2. Married 2. Married 2. Married 2. Married 2. Married 2. Married 2. Married 2. Married 3. Marr			ican Indian, Black,
s after deat rral", or its niner musi		1 Yes 2 No No specify:		Specify.	hite
5-0036 ed within 72 hours tygiene other than "natu the Medical Exar	-	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Customer Serv. Rep.		16b. Kind of Business	
215-00% be filed with ntal Hygiene riked other tilen, the Mec ent, the Mec Be Com		77. Father's Name (First, Middle, Last)	Name (First, Middle, Market)	Maiden Surname)	
AD 212 2 should be 1 and Mentz 27 is mark matic even To B		9a Informant's Name/Relationship (Type, Print) Darren Silk/son 19b. Mailing Address (Street and Number 15537 Cattail Oaks)			e, Zıp Code)
Baltimore, MD 21215-0036 semit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine (important: If item 27 is marked other than "natural", or items 23a or 28a-f shonjury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	ı	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 10/11/06	20c Location - City of Fallston,	
Baltimo permit. Page. Department of Important:	1	21. Superture of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funer	al Home of	Bel Air,	Inc.
Physician /Medical Examiner	-	Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):	diac or respiratory arro	est, shock, or heart	Approximate Interval Between Onset and Death
ted nisit Examiner	-valling-	b. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
60, ate be executed ohysician and burial - trans		UNPENDED #1, perME, g861, 11/15/06 TT			
box 68760, the death certificate be by the attending physiciched for use as the buriched for use as th		past 12 months? 4 Pregnant at time of death 5 Other (Specify)	pregnancy	23d Date of deliver Month	y Day Year
P.O. Bost the degree by the detached for the physical by the bost the bost the bost the bost the bost bost bost bost bost bost bost bost		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		bbacco use contribute to	
Division of Vital Records, P.O. Box 68760, rat or Attenting Physician: The law requires that the death certificate be executed as after death. The law requires that the death certificate be executed and prector. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transit partification: To Be Completed by Physician/Medical Experience.	Inplicitor		24a. Was	an 24b. Were a prior to med? death?	utopsy findings available completion of cause of
tal R cian: T certifica ector, pa	۶ ۲	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other4	Check only one)		
n of Virding Physical dispersed disp		1 Ves 2 No lose Injury 2 ER/Outpatient 3 DOA 1 One 4 2 ER/Outpatient 3 DOA 2 One 4 2 27. Manner of Death 1 Day Year) Oct 6, 2006 Pending 1 Yes 2 Ves	28d. Describe	Residence 6 Other how injury occurred struck by auto	r:
Division o spiral or Attending hours after death hours after death heral Director. After filled in by the fune for the forest or after forest	linear	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Major Road / Highway	28f. Location (\$ or Town, \$		ural Route Number, City
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certificantletely filled in by the funeral director.	olcal C	29a Certifier 1 Certifying Physician: To best of my knowledge, death occurred at the time, date and place cone) 2 Medical Exam r: On e basis of examination and/or investigation, in my opinion, death occurred at the time, date and place cone)	e, and due to the caus	se(s) and manner as sta	rted
T N N N N N N N N N N N N N N N N N N N	2	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mo	
20		30. Name and address of person who completed cause of death (Item 23a) David Fowler M.D. Chief Medical Examiner 111 Penn Street, Baltimore, MD 2	1201		
Stat Registra	~	31 Date filed (Month, Day, Year) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien () [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SIMPSON 19976-62 **Physician** MITCHELL 9.08 p.M 2006 /Medical 4c. County of Death Examiner Facility Name (If not institution, give street and number, ital 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday **Funeral** 60 100 M 2□ F 64-Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "naturel", or itsme 23a or 28a-f show yinjury or other traumatic avent, the Medical Exacting must be notified at once. 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 □ No **Funeral Director** more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 121 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unemployed IVI Id 17. Father's Name (First, Middle, Last) Be Daniel 19a. Informant's Name/Relationship (Type, Print) [mother] 19b. Mailing Address (Street and Number or Runal Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition-1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Facility I Seph L. Russ 2222 W. North Ave 21. Signature of Funeral Service Licenses tuneral Balto Ma Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Squamon cely carlina co Immediate Cause (Final dranced Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physicien and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 20 2 No after death.

Director: After this certifice in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Dinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide To the Hospital within 24 hours a To the Funars! Completely filled in 29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified er 5th 2006

State Registrar 31. Date filed (Month, Day, Year)
UCT 1 0 2006

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

of Sparks

ORIGINAL

			1 - For State Registrar	State of Marylan	-	artment o		h	R	eg. No. UU	6 31985
	Physici	an	Decedent's Name (First, Middle, Las DEATED TOP:	•	0.01				2. Date of Deat Month	Day Y	3. Time of Death
١.	/Media	cal	BEATRICE	R OSE	SCI	INE IDER	wn, or Locatio		OCTOBER	7, 2006 4c. County of	2:00 A
	Examir	ier	4a. Facility Name (If not institution, give 5707 CHURCH ROAD			BOW1		in or Death		,	E GEORGE'S
~	Funeral		Social Security Number 6. Se	7. Age (In yrs. I	ast birthday)	If Under 1 Y	ear If Und		8. Date of Birth (Month, Day,	9	Birthplace (State or Foreign Country)
D	Director		219-54-7088	^{™ 2}	Yrs.	Months D	ays Hour		JAN 6,		MARYLAND
	pug M		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Manyl	ro			OWIE						1 X Yes 2 □ No
	r 28a	rec	10e. Street and Number	OLOROL B B	7W I I	10f. Zip Co	ede		1	0g. Citizen of Wha	at Country?
	th with	Funeral Director	5707 CHURCH ROAD			207	20			U.S.A.	
	r dea	Iner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent f Yes, specify	of Hispanic Cuban, Mexic	Origin? (Spec can, Puerto R	ify Yes or No- ican, etc.)		American Indian, White, etc.
36	rs afte	by Fu	1 Never Married 2 Married 3XXWidowed 4 Divorced	1 ☐ Yes ŽŽŽNo If Yes, Give Year or Dates:		1 □ Yes 2 🔀	No Speci	ify:		Specify:	WHITE
21215-0036	d within 72 hours after death with the Maryland Jone. r than "natural", or items 23a or 28a-1 show the Madical Exert art must be traffied at		15. Decedent's Ed	ucation	16a. Dece	dent's Usual O	ccupation			16b. Kind of Busir	ness/Industry
215	within 7. ene. than "n	Completed	(Specify only highest grad	College (1-4or 5+)	life.	kind of work a DO NOT use r	etired)	ost of workin	9		
2	filed wil Hygien sther th	Con	12		ENT	REPRENE				GENERAL	STORE
Maryland		To Be	17. Father's Name (First, Middle, Last) CLIFFORD LANHAM					ELEN	BRADY	Maiden Sumame)	
lary	2 should be and Mental is marked raumatic ev	-	19a. Informant's Name/Relationship (7		1					City or Town, St	
d)	s 1 and f Health item 27 other tr		HELEN FAY SCHNEIDE 20a. Method of Disposition			SHURCH sition (Name)		BUWIE,		AND 20720 20c. Location - Ci	
Baltimore,	permit. Pages: Department of the Important: If ite any injury or ot once.		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crer	natory or othe DLN CEM	r place)	1			D, MARYLAND
İtin	artme ortan injuri		4 □Donation 5 □Other (Specify 21. Signature of Funeral Service License		_						NERAL HOME,
ñ	Depa fmpo any i		> You Proces	is							AND 20715
ě	Di-		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.							Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. CEREBR Due to (or as a consequence)		COLA	/ /N	FAR	2//0/	4	MONETHS
3-3	Examiner		Sequentially list conditions	b							
7	D tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as a consequ	uence oi):						
	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence)	uence of);			_			
8760		20		ď	,						
9	death certificate e attending phys id for use as the	ledic		·							
Вох	leath certifica attending ph I for use as th	an/N	23b. was decedent pregnant	23c. If yes, outcome of pregna		Ectopic pregr	nancy			23d. Date of Month	The state of the s
O.	he dea the at	Physician/M	in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	4☐Pregnant at time of de 9☐Unknown	eath 5	Other (special	fy)			World	Day real
Ω.	law requires that the des been signed by the		Part II. Other significant conditions co	ontributing to death but not rest	ulting in the u	nderlying caus	se given in Pa	ırt I.	23e. Did to	bacco use contribi	ute to the cause of death?
Records,	w requires been signe should be	ed by							1 □ Ye	as 2 No 3	☐ Probably 4 ☐ Unknown
000	e law re hes bee ge 2 sho	ompieted							24a. Was a autops		re autopsy findings available or to completion of cause of
Ä	The ate h page	Com							perform	ned? dea	ith? Yes 2□ No
Vital	Physician: this certifica	Be	25. Was case referred to medical examiner?	Hospital:			0		(Check only on		
of	Phys r this ral dii	T.	1 Yes 2 No 27. Manner of Death	1 Inpatient 2	ER/Outpatier 28b. Time o					ence 6 Other	
O	Attending I r death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	М	Injury at Work? 1 Yes 2			,,	
Division	il or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifi		eet, factory, or	ffice	2	8f. Location (Si City or Town		or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in b		29a. Certifier 12 certifying Ph	ysician: To the best of my kno		n occurred at the	ho timo, data	and place a	nd due to the e	auga(a) and mana	or so stated
	the Hos nin 24 ho the Fun npletely	edicai	(Check only 2 Medical Examone)	iner: On the basis of examina and manner stated.	tion and/or in	vestigation, in	my opinion, o	death occurre	d at the time, d	ate and place, and	d due to the cause(s)
	To the To the Comp	ž	29b. Signature and itle of certifier	1000			icense numbe				Month, Day, Year)
•			Fels m/m	Ille M			122	780		10/7/2	2006
	6		30. Name and address of person who of	completed cause of death (Item	(Type,	Print)	Cr B	V. (3	reen be	10/7/3 14,MD	20770
4	Sta		31. Date filed (Month, Day, Year)	32. Régistrar's Signa	ture	7			. = -7, 00	, , ,	
	Regist	rar	DCT 1 0 3	2006	10	Carl 8					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Registrar Certificate of Death Ren. No. 2. Date of Death Say 2006 1. Decedent's Name (First, Middle, Last) **Physician** William T. Steinacker, Sr. October 8, 11:12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2820 Hoffman Avenue Baltimore Highlands Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 → M 2 □ F Months Days 220-05-3052 85 Sept 16, **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at MD 1 ☐ Yes 2 X No Director Baltimore Baltimore Highlands 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2820 Hoffman Avenue 21227 U.S.A. Completed by Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Item any filury or other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Elementary/Secondary (0-12) College (1-4or 5+) Education Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer W. Steinacker Edna G. Brewer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandi Taimeh/Daughter 503 S. Hammonds Ferry Rd. Linthicum MD 21090 20b. Place of Disposition (Name of cemetery, denatory or other place)
Mary Land Veteran Cemetery 20a. Method of Disposition 20c. Location - City or Town, State ¶ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 10-11-06 Crownsville, MD at Crownsville ddress of Facility Ambrose Funeral Home of Lansdowne 21. Sign ture of Funeral Service Licen 2719 Hammonds Ferry Rd. Lansdowne MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 5 years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician as the burial-t Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Be Completed by Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 \(\sum \) Nursing Home ۵ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Dav. Year)

32. Redistrar's Signature

			For State Registrar		State of	Marylar	-	partment of Fertificate of				gien Reg. N	ZUUh	3	1987
	Physici		1. Decedent's Name (First, M	iddle, La	0	NCHCC	mB				Date of Dea Month	ath Da		-	Time of Death 7
	/Medic Examir		4a. Facility Name (If not institution Bathmore Wash	ition, giv	e street and num	nber)	ten	4b. City, Town, o	rLocation	of Death			County of Dea		del
	Funeral Director		220-22-4441	<i>9</i> . S	ex M 2□F	7. Age (<i>In yr</i> s. 80	last birthda Yrs.	Months Days	If Under Hours	24 Hrs. 8. Min. No	Date of Birt (Month, Day OV • 29	h y, Year 1	9. Bir 925.	thplace ountry)	(State or Foreign
	show	Į.	Usual Residence of Deceden 10a. State 10b. Cou	inty			ty, Town or								nside City Limits ☐ Yes 2 No
	deeth with the Maryland ms 23a or 28e-f show finust be notified at	Director	10e. Street and Number		ındel	GI	en Bur	10f. Zip Code				10g. Ci	itizen of What Co		
<u>⊢</u> , %	5 ± 2	by Funeral	1021 Glen Vi 11. Marital Status 1 □ Never Married 2 □ 0 3 ☑ Widowed 4 □ Divor	Married	Y	2 ∐No e	.S. 13	2106] Was Decedent of H If Yes, specify Cuba			y Yes or No- an, etc.)		S.A. 14. Race - Ame Black, Whit		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or its any njury or other traumatic event, the Middle Examina any njury or other traumatic event, the Middle Examina and once.	Completed t	15. Dece (Specify only hi Elementary/Secondary (0-1 1 2	dent's Ed	ducation		(Gir	edent's Usual Occup le kind of work done DO NOT use retired	eation during mos	st of working			Kind of Business		
$\sqrt{\epsilon}$	ld be filed ental Hygid ked other ic event, III	To Be Co	17. Father's Name (First, Mid Joseph Davis)		naci			er's Name (F					
CHCOMB ore, Maryl	nd 2 shoul lith and M 27 is marl r traumati	-	19a. Informant's Name/Relat Mrs. Michele	onship (aughtei		ling Address (Street	and Numb	er or Rural R	oute Numbe			Zip Cod	e)
STACAL Baltimore,	Pages 1 ament of Heament: If item		20a. Method of Disposition 1 □ Burial 2 □ Cremati 4 □ Donation 5 □ Othe	on 3□	Removal from S	20b. F	Place of Dis cemetery, cr	position (Name of ematory or other place) ven Mem.	ce)	Oct. 1 2006	1,	20c. L	ocation - City or en Burni		
	permit. Departition of the point of the poin		21. Signature of Funeral Service	ice Licer	Shuk	MOIL		22. Name and Addre		DILLE			neral Ho e MD 210		P.A.
•	Physician /Medical Examiner	ler	23a. Pant1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to minediate	e, or com List only	a. Due to (ach line.	uence of):	nter the mode of dyin		s cardiac or re	espiratory ar	rest,		Inte	oroximate rval Between set and Death Weal
68760,	tificate be executed ig physician and as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c. Due to (or as a conseq	uence of):								
Division of Vital Records, P.O. Box (it the death certif by the attending tached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			irth 2 ☐ Feta ant at time of d	I death 3	□Ectopic pregnancy □ Other (specify)	/				23d. Date of de Month	livery Day	Year
ords, F	v requires the been signed I should be det		Part II. Other significant con	ditions o	contributing to de	ath but not res	ulting in the	underlying cause giv	en in Part	i.	23e. Did to		use contribute to		use of death? 4 ∐Unknown
al Reco	ysician: The law requiscentificete has been director, page 2 shoul	e Completed	25. Was case referred to me	linal)			3			1□ Yes	rmed?	death?		indings available tion of cause of No
of Vii	Physicia r this cert and direct	To B	examiner? 1 Yes 2 No 27. Manner of Death	iicai	10	npatient 2 of Injury h, Day Year)	ER/Outpati		er: 4 🗆 Ni		5 ☐ Resid	dence	6 □Other (Spe	icify)	
Division	To the Hospitel or Attending Physician: The law requires that the death certifit within 24 hrurs after death. To the Furnarel Director: After this certificate has been signed by the attending t completely filled in by the funeral director, page 2 should be detached for use as	Certification;	3 ☐ Suicide 6 ☐ Co	nding estigation uld not b ermined	e 28e. Place		Injury ome, farm, : y)		k? Yes 2⊡		Location (S City or Tow	Street a vn, Stat	nd Number or Ri	ural Rou	ite Number,
	he Hospi in 24 hour he Furrer pletely fill	edical	29a. Certifier 1 Cert (Check only one)	fying Ph cai Exar	nysician: To the niner: On the ba and mann	isis of examina	wiedge, de ition and/or	ath occurred at the tin investigation, in my o	ne, date ar pinion, dea	nd place, and ath occurred a	due to the o	cause(s date an	s) and manner as ad place, and due	s stated.	cause(s)
	with Com	Σ	29b. Signature and title of cer	tifier	5 Cul	Er al	Th	29c. Licens	a number	128	5	29d. Da	ate signed (Mont	th, Day,	Year))6 2006
	U	te	30. Name and address of per 31. Date filed (Month, Day, Y	2	32. Re	oistrar's Siona	tou	Madica	heer (EWI	ور س	G	STU B	H'M	= 141)
	Regist	ar	OCT	1 0 2	006	College .	B. J	pede							

			1 - State Registrar	State of Man		artment of F		-	giene Reg. No.		31988
			Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Physici		Kathleen Estell	e Schemm				Octobe	r 8.	2006	10:20 A. ^M
7	/Medio Examin		4a. Facility Name (If not institution, give s.	treet and number)		4b. City, Town, o	r Location of Dea			County of De	
			St. Elizabeth N	ursing Hom	e	Balt:	imore				
	Funeral		Social Security Number 6. Sex		n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th v. Year)	9. E	irthplace (State or Foreign Country)
	Director		213-07-7408	M 21X F 90	Yrs.	Month of Says		July 1			aryland
	pu *		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation					10d. Inside City Limits
	/ sho	ō									1X Yes 2 □ No
	28a-	Director	Maryland 10e. Street and Number		Baltimor	e 10f. Zip Code			10g. Citi:	zen of What	Country?
	with a or										,
	ne 25	era	3320 Benson Avenue	2. Was Decedent Eve		Vas Decedent of H	lispanic Origin? (5	Specify Yes or No	USA	14. Race - Ar	nerican Indian,
(0	rher	Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No	1	f Yes, specify Cuba	an, Mexican, Puer	rto Rican, etc.)		Black, Wi	
ğ	esl', o	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		I□Yes 2X No	Specify:			Specity:	White
ည်	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	fent's Usual Occup	ation during most of wa	orkina	16b. Kir	nd of Busines	ss/Industry
7	ithin	npie	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	life. L	DO NOT use retired	d)	9			
2	ygier yerth				Hom	emaker				vn Hom	e
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or items 23a or 28a-f show event. If a Marilinal Estatular Investigation of the contilled at	Be	17. Father's Name (First, Middle, Last) James Jacobs,	Sr				me <i>(First, Middl</i> e 11e Emic		Sumame)	
<u> </u>	2 should be and Mental Is marked o	욘			400 14 70					T	7-0-4-1
Z Z			19a. Informant's Name/Relationship (Typ	•		ig Address (Street			000		
e) O	1 and 2 Health tem 27 other tra		Linda J. Wessells 20a. Method of Disposition	Daughte	20b. Place of Dispo	oanoke Dr sition (Name of		tonsvill Date			d 21228 or Town, State
õ	Peges nent of int: If It		1 Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, crem Lorraine]	natory or other place Park Ceme		/11/2006			
altimore,	artme ortan injur		4 □Donation 5 □ Other (Specify) 21. Signature of Feneral Service License								ab Witzke
Ba	permit. Peges 1 and Department of Heal Important: If Item 2 any injury or other 2005.		Hohong &	NS		Funeral H	Home of (Catonsvi	11e.	Inc.	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the	death. Do not enti-	er the mode of dying	ng, such as cardia	zenue; Ca	atons rrest,	sville	MD 21228 Approximate
	Physician		Immediate Cause (Final		utestinal						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a c		301908	lage				dup
Н	Examiner										
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a ci	ഗ്നാ പ്പേരലാശ വ്).						
) .	ocuted nd transi	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events								
Ö,	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):						
8760,	cate b	dicai	d								
9 ×	death certificate be executed e ettending physicien and id for use as the burial-transit	Mec	IF FEMALE:	20 16							
Box	ath c	ian	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1☐Live birth 2 ☐	Fetal death 3	Ectopic pregnancy	/		2	3d. Date of one of the Month	lelivery Day Year
o.	at the de by the (tached	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	e or death 5	Other (specify) _					
٦	The law requires that the le has been signed by the lage 2 should be detache		Part It. Other significant conditions con	tributing to death but n	ot resulting in the ur	nderlying cause giv	en in Part I.	23e. Did 1	obacco u	se contribute	to the cause of death?
Vital Records,	w requires that been signed b should be deta	d by						10	Yes 2	□No 3□	Probably 4 DUnknown
Ö	w req	iete						24a, Was	an	24b. Were	autopsy findings available
He	The lav	Completed						auto perfe	psy ormed?	prior t death	o completion of cause of
		ပို	25. Was case referred to medical				26 Place of De	1 ☐ Yes eath (Check only		1 🗆 Y	es 2 No
	ysici is cer direct	To B	evaminer?	ospitat:	2 ER/Outpatien	t 3 DOA Oth		Home 5 ☐ Resi		□Other (St	pecify)
0	Attending Physician: r death. sctor: After this certific by the funeral director.		27. Manner of Death	28a. Date of Injury (Month, Day Ye		28c. Injur Wor		28d. Describe			
Ö	uttendir death. ctor: Af y the fur	atic	1 ☑Matural 5 ☐ Pending 2 ☐ Accident investigation	(,,		Yes 2 □No				
		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, stre Specify)	eet, factory, office		28f. Location (City or To			Rural Route Number,
	Hospital or At thours after of Funeral Directely filled in by										
	e France	edicai	29a. Certifier 1 Certifying Phys (Check only one) 2 ☐ Medical Examin	icien: To the best of mer: On the basis of ex	amination and/or inv	occurred at the tire occurred	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner place, and d	as stated. ue to the cause(s)
	To the Hos within 24 ho To the Fun completely	Mec	29b. Signature and titte of certifier	and manner stated		29c. Licens	e number		29d, Date	e signed (Mo	nth, Day, Year)
	F 3 F ŏ		Darles Phelan	- Ar m		nzu	2 81		Och	les e	7 21212 (
	À		30. Name and address of person who con	0	h (Item 23a) (Tyne	Print)	- 00 /		00,0		,
	K			Hun or	100/ P	re was	no are	5300	Borr	we.	ma war
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	make E		//			noth, Day, Year) 7, 200 L ma L(115
	Registr	ar	OCT 1 0 200	6 December	150 85	William Control					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TITE 1, per PHYS., 050, 10/10/06, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 31989 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Helen L. Stewart Day Physician 00 55 AM September 25 TEWART 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE N/A MERCY MEDICAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days Hours 220 18 9110 8 | Yrs. February 26,1925 MD Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County tem 27 is marked other than "naturel", or items 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Director MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a eny injury or other traumatic event, the Madical Examinational once. 2467 Etting Street 21217 U.S.A. Funerai 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Black þ 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Investigative Clerk Dept. of Defence na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sadie Forrester ပ Spicer Laws 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Stewart-Walker-Daughter 2467 Etting Street, Balto, Md 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crownsville Vet. 10/02/06 Crownsville, Md 21. Signature Funeral Service Licensee 22. Name and Address of Facility March F/H West 3a. Pay(1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) **Physician** Hemorrhagic cerebrovascular accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 X No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) Leitherdmo 1311586 Stptimber 25, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #6 227 21201 Baltimore, MD MATHAD Paul ST Place 1 TOY L 22. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 0 Registrar

Please Type or Print in Black Indelible Ink

Christopher Sturgeon State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner October 4. 2006 1910 hrs Sturgeon Christopher 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 528 Kuethe Drive Glen Burnie Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) Funeral Months Days Hours Director 219-80-0065 31 02/07/1975 Country) 1 X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits Inv Anne Arundel 1 Yes 2 X No 28a-f show Maryland Pasadena Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene ant. Filem 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be nofified at once Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 21122 3 Carvel Court 21122 Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? White etc. Yes if Yes, Give Year 3 Widowed 1 Yes 2 X No specify. Specify: White ≦ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Electrician Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joellen Voluse Sturgeon John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 836 Turf Valley Drive, Pasadena, MD 21122 John N. Sturgeon Sr. (father) permit. Pages I and 2
Department of Health
Important: If item 2
injury or other traus 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date Oct. 06 crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2006 Baltimore, Maryland Donation 5 Other Specify Metro Crematory Inc. 21. Signature of Funeral Service Dicens 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician 23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. Between Onset and /Medical Death Hydrocodone and alcohol intoxication Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed and ian/Medical X UNPENDED AMENDED item#23a,PII,27,28a-f.perME.e860,10/20/06 TT Division of Vital Records, P.O. Box 68760 attending phys or use as the bu IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Yea 2 Fetal death past 12 months? Pregnant at time of death Physici 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Atherosclerotic cardiovascular disease Completed 24a, Was ar 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? After this certificate ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 V Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death Certification: 1 Natural 1 Yes 2 X No 5 Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the Fnd 10/4/2006 Fnd 6:30 pm subject ingested drug Accident Investigation 28f. Location (Street and Number of Rural Route Number, City or Town, State) 528 Kuethe Drive 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 X Suicide Could not be (Specify) house Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME m.D October 5, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 31. Date filed (Month, Day State 0 2006 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician October 2006 11:10 P^M Kerry W. Sutphin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 139 Baltimore Avenue Dundalk Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6. Sex 1 ★ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 216-30-8162 72 Yrs. 1934 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show ust be notified at 1 ☐ Yes 2 XNo Maryland Baltimore Dundalk Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 139 Baltimore Avenue 21222 USA Funerai Race - American Indian, Black, White, etc. r than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: White 3 MWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If Itan 27 is marked other 11 any Injury or other traumatic event. The once. Printer Printing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Noble Belton Sutphin Bessie Adell Smith 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee F. Sutphin/Brother 139 Baltimore Avenue Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/7/06 Baltimore, MD 21. Signature of Euneral Service Ligensee 22. Name and Address of Facility Cremation Society of MD, Edward A. Stegorchik 299 Frederick Road Baltimore, MD 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METITATIC 11 MONTY! /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner I Records, P.O. Box 68760, E.g. The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b autopsy performed? Yes 212 No 1 ☐ Yes To the Hospital or Attending Physician: Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 ▼ No Hospital: Cther: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of 28c. Injury at Work? Certification: 27. Manger of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760, within 24 hours after deat To the Funeral Director:

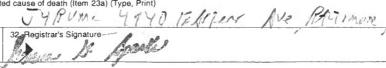
> State Registrar

MILMARL 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

witter

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

29c. License number

0147161

29d. Date signed (Month, Day, Year)

October 6, 2006

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death	Reg	No. 200	6 3 1 9 9 3
Physician	114		Date of Death Month	Day Year	3. Time of Death
Medical Examin		Mary Sue Stearns 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Month I September	29, 2006 4c. County of Deat	1010 hrs
		6900 Mornington Road, Apt. C Dundalk		Baltimore Co	
Funeral	7	5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8 Date of Birth	(MM/DD/YYYY) 9. Bi	
Director		216-38-4891 1 M 2 XF 65 Yrs. Months Days Hours Min.	09/30/3	1940 Forei	gn puntry) MD
	t	Usual Residence of Decedent			
w any	1	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show d at once.	<u>ا</u> دِ	MD Baltimore Dundalk			1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code	10g	Citizen of What Cou	intry?
ith the		6900 Mornington Road, Apt. C 21222 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	ufu Von or No	USA	ican Indian, Black,
eath w	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No		White, etc.	icar indian, black,
ifter d	훳.	3 Widowed 4 XDivorced of Pates: 1 Yes 2 X No specify: or Dates:		Specify: 1	Vhite
5-0036 led within 72 hours after death with the Maryland Hygiene other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of working life, DO NOT use retired		16b. Kind of Business	Industry
36 n 72 } nan "r iical E	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	·'		
0036 within giene her than	틹	12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (F	iret Middle Ma		re Farms
21215-0036 uld be filed within 7 Mental Hygiene in marked other than c event, the Medica	ည္ Be	Raymond O. Stearns Ena Mae			
21; ould b i Men i marl		19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			e, Zip Code)
MD d 2 sho llth and n 27 is		Raymond L. Stearns Brother 12664 Landview Drive,			
re, s I an of Hea of Titer	1	20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
imo Page ment o lant: or otl		4 Donation 5 Other Specify: Carroll Cremation 10/2	/06	Hampstead	i, MD
Baltimore, permit Pages I an Department of Hes Important: If Hes injury or other tr		21. Signature of Funeral Service Licensee 22. Name and Address of Facility			rstown Road
	4	23a. Part I I nter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or re			, MD 21136 Approximate Interval
Physician /Medical		failure. List only one cause on each line.	sophatory arres	t, shoot, or heart	Between Onset and Death
Examiner	-	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			
- 1		Sequentially list conditions, b.			
	.⊑I	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed an and al - trans	ᇹ	d			
0 7 7	edical	UNPENDED			
	<u> </u>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	v	23d. Date of deliver Month	y Day Y ear
Box 687 he death certific	Physiciar	4 Pregnant at time of death 5 Other (Specify)	,		
BOX he death co	چَا	1 Yes 2 V No 9 Unknown 9 Unknown	00: D 14:1		
ires that the signed by the detached	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. metastatic carcinoma		acco use contribute to	the cause of death?
rds, l		inetastatic carcinoma	24a Was an		utopsy findings available
cords law require has been so 2 should	ompleted		autopsy	prior to	completion of cause of
Vital Recystrian: The list certificate director, page	O L		1 Y Yes 2		es 2 No
ital sician:	ğ۱	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing F		anidana C. A. Ouha	- C
er g gar	유	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 128c. Injury at Work? 28		esidence 6 🗸 Othe winjury occurred	r: Scene
On Con conding ath.	ertification:	1 V Natural 5 Pending (Month, Day, Year) 1 Yes 2 No			
visior or Attend ther death inector: in by the	<u>≅</u>	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28	Bf. Location (Str	eet and Number or Ru	ıral Route Number, City
	()	4 Homicide determined (Specify)	or Town, Stat	te)	
e Hos n 24 ho e Fun		29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and duranteed to the control of			
To th within To th	e L	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated			117
_ ~	2	29b Signature and title of certifier 29c License number O.C.M.E.		29d Date signed (Mo	, ,
		orange the orac		September 30, 2	.000
80	,	30 Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21:	201		
Sta	te	31 Date filed (Marth Day Verd) 22 Profitted Cignature		 .	
Registr		OCT 1 0 2006 Server & Apoll			

			1 - For State Registrar	State of N	Marylan	-	artment of F tificate of			giene 2006	31993
	Physici		1. Decedent's Name (First, Middle, LILLI		SHER	MAN 2. Date of Month OCTOB			Day Year	3. Time of Death 10:38 A M	
}	/Medio Examir		4a. Facility Name (If not institution, s		er)		4b. City, Town, o	r Location of Deat	h	4c. County of Dear	
	Funeral Director				Age (In yrs.	la <i>st birthd</i> ay) 8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birtl	9. Bin	hplace (State or Foreign NY
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	the Mar 28a-fat cuttled	ector	MD No. Street and Number	N/A		BALT	IMORE			10g. Citizen of What Co	1 X Yes 2 □ No
	23a or	Funeral Director	2804 STEELE ROA	√D			101. Zip Code	21209		Tog. Onizer of What of	USA
36	hours after death with the Maryland turst', or Itams 23s or 28s-f show at Exercinet must be notified at	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ૹ Widowed 4 ☐ Divorced	12. Was Decede Armed Force d 1 Tes 2 If Yes, Give Year or Date	S? XINo		Was Decedent of H fYes, specify Cuba I□Yes 2X No	lispanic Origin? (S an, Mexican, Puerl Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify:	
5-003	22 28	eted	15. Decedent's (Specify only highest	Education		(Give	lent's Usual Occup	durina most of wo	rking	16b. Kind of Business	Industry
212	filed within Hygiene. thar than ent, the Me	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)	HOMEM	OO NOT use retired IAKER	<i>=)</i>		OWN HOME	
and	id be ental ked o	To Be (17. Father's Name (First, Middle, La	est)		BANK		18. Mother's Nar BESSI		Maiden Sumame)	TOONKEL
Maryland	2 shou and M la mar	-	19a. Informant's Name/Relationship							r, City or Town, State, a	Zip Code)
_	ss 1 an of Heal litem 2 r other		STEVEN SHERMAN 20a. Method of Disposition			lace of Dispo	sition (Name of natory or other place	1	Date	, MD 21209 20c. Location - City or	Town, State
Baltimore,	permit. Pages Department of important: If Its eny Injury or o		1 M Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	ocify)	10	H JACO	В СЕМЕТЕ	RY 10/	09/2006	FINKSBURG	•
eg —	Depz Impo	9 8	Scalf M.	attle						PIKESVILLE,	•
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List or tmmediate Cause (Final	inplications that caus thy one cause on each	ed the death	1			1		Approximate Interval Between Onset and Death
*	/Medical Examiner		disease or condition resulting in death)	a Due to (or	as a conseq	yence of):	140 caus	ald in	Jane L	la disa	acute
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a conseq	ence of):	ellro+	caud	wowara	a disa	15420
4	icate be executed physician and s the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last c								
8/60,	E € =	dicai		d							
C. Box	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/Me	tF FEMALE: 23b. Was decedent pregnant in the past 12 moows? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcon 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	Ideath 3□	Ectopic pregnancy	,		23d. Date of del Month	ivery Day Year
ecords, P.	w requires that I been signed by should be detai	by	Part It, Other significant condition	s contributing to death	but not res	ulting in the ur	nderlying cause giv	en in Part I.		bacco use contribute to	othe cause of death?
r	The ate h	Completed							24a. Was a autop perfor	med? death?	itopsy findings available completion of cause of 2 No
VITa	siclan: certific rector,	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ tnpa	ationt 2	ER/Outpatien	t 3□ DOA Oth	or	ath (Check only or		Assertal
n or	ding Phys h. After this funeral di	H-1	27. Manne of Death 1 Natural 5 Pending	28a. Date of tr (Month, I		28b. Time of Injury	28c. Injur Wor	y at k?		ence 6-30ther (Spe ow injury occurred	Living
DIVISION	or Attended ter deatlinector:	Certification;	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine		tnjury - At ho etc. (Specif	ome, farm, stre	M 1 ==	Yes 2 □ No	28f. Location (S City or Tow	treet and Number or Run, State)	Iral Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Madical Ex	Physician: To the be caminar: On the basis and manner	of examina	wledge, death	occurred at the tir restigation, in my o	ne, date and place pinion, death occu	a, and due to the curred at the time, c	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within ? To the comple	Med	29b. Signature and title of certifier	4	/		29c. Licens			29d. Date signed (Mont	
)	6		30. Name and address of person wh	no completed bause of	f death (Item	23a) (Type	D~/6	090		10-5.20	06
			H. Gereld	'OsteR	MO	363	5 old	Court	Road	PIKESUII	16 Hd 21200
ar.	Sta Registr		31. Date filed (Month, Day, Year) 0 CT 1 0	2006 32. Asgit	Surar S Signa	E A	note!				

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Month Year 10:58 a [™] C. Helen Suitt 10/02/2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Frederick Villa Nursing Home Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖫 F 214-03-1392 12/30/1913 Director 92 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show r than "natural", or items 23a or 28e-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 → No Funeral Director MD Howard Columbia 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9131 Gracious End Ct. 21046 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. hours after 1 □ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☑ Never Married 2 ☐ Married Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation within 72 (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Accounting 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rmit. Pages 1 and 2 should be fill partment of Health and Mental H portent: If itsm 27 is marked off y injury or other treumatic even Be Edward B. Sargent Sr. Lucy Edna Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Lee Suitt / Daughter 9131 Gracious End Ct., Columbia, MD 21046 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Importent: If i Metro Crematory 10/05/2006 Catonsville, MD Cary L. Kaufman Funeral Home at MMP, INC. 21. Signature of Funeral Service Licer pnce M01378 7250 Washington Blvd., Elkridge, MD 21075 ant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, both, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): physician sthe burial Box 68760. Physician/Medical as IF FEMALE use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown ō Month Day 5 Other (specify) P.O. the 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe 2 No 1 🗌 Yes 2 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Tes ffirsing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Deal 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending death. 1 □ Yes 2 □ No investigation thei within 24 hours after death To the Funerel Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide ths Hospitel rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50303 30. Name and address of person wh of mpleted cause of death (It 23a) (Type, Print) SIGN Rolling Rd Ste 205, 21228 Fernandot Kodolto 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 21Day 3. Time of Death Physician sept. Florence Emmert 2006 Sieling 5:53 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13506 Villadest Drive Highland Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 19, 1931 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Virginia **Funeral** 1 ☐ M 2 🛣 F Yrs, Director 577-40-0328 75 Usual Residence of Decedent with the Maryland is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Menial Hygiene.
Item 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic event, the Medical Evanting must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2 🖾 No Director Howard Highland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13506 Villadest Drive 20777 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 XNo Specify þ 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clagget Emmert Margaret Slocombe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If Item 27 le ury or other trae Barry D. DePauw (Son-in-law) 13506 Villadest Drive Highland, MD 20777 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State

'4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or 10-6-2006 Metro Crematory Catonsville, Maryland 21. Signature of Funeral Service Licensee ^{22, Name, and Address of Facility} Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOGARNIA Hora /Medical Due to (or as a consequence of): Examiner HYPERTENSTON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical the as attending IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 5 Other (specify) P.O. 1 the i ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ CIMONIU OBSTRUCTUS 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? page certificate Division of Vital 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 sesidence 6 Other (Specify) ٩ 1 ☐ Yes 2 No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m 30. Name and address of person the completed cause of death (Item 23a) (Type, Print) 3446 OMM ENGUN WE FILTE and think Ison demanders ounder my 20835 31. Date filed (Month, Day, Year)
OCT 1 0 2006 mo State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 6 31996 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jouce L. Tooraen October 2006 9:00 A 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Brightview Senior Living White Marsh Baltimore Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year)
Aug. 14, 1 5. Social Security Number If Under 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 ☐ M 2 🖫 F 89 437-05-5536 Yrs. 1917 Louisiana Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1X Yes 2 No Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2912 Rosalie Avenue 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel LoBlanc Elodie. Templet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Bovaird (daughter) 2912 Rosalie Avenue, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 10/10/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes una leel 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death vee of delivery Day

Physician /Medical Examiner

permit. Page Department c important: if any injury or once.

Physician

Examiner

Funeral

Director

Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene and the Health and Mental Hygiene ant: If item 27 is marked other than 'natural', or items 23a or 28a-f show any or other traumatic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

/Medical

10a. State

Examiner Completed by Physician/Medical Be Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

disease or condition resulting in death)	a Trong revile		1 (use)					
resulting in death)	Due to (or as a consequence of):							
Sequentially list conditions, if cary, learning to intribudiate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of).							
that initiated events resulting in death) Last	c. Due to (or as a consequence of):							
•	d.		gagnitus.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23b. Was decedent pregnant in the past 12 gronths? 1 Yes 2 KNo 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?					
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
25. Was case referred to medical examiner?		Check only one						
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 Other (Specify) Assisted					
07 Manager of Dogsth		20.10	11331910					

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ithin 24 hours after death.

o the Funeral Director: After this certifical impletely filled in by the funeral director.

vithin 24 hours a

State Registrar

Medicai

Rannama 31. Date filed (Month, Day, Year) 0 2006

5 Pending

investigation

6 Could not be determined

27. Manner of Death

Natural

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

29b. Signature and title of certifier



28a. Date of Injury (Month, Day Year)

Botto HD

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Living

ORIGINAL

28c. Injury at Work?

Certifying Physician: To the best of my knowled ie, death occurred at the time, date and place, and due to the cause's and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

1 ☐ Yes 2 ☐ No

			1 - For Amend #4a	a Per Phy	3860 I	10/25/ Cel	rtificate of I	ieaith and r Death	vientai Hy	gien Reg. N	e 2006	31997
	Physici		Decedent's Name (First, Middle, L Barry	,	Thomas	S			2. Date of De Month	Di	ay Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, g	ive street and number)			, , , , ,	Location of Death	Octobe		• 2006 c. County of Deat	8:56P M
1		**	Fair Land Nur 5. Social Security Number 6.	sing houe	ng Hor ge (In yrs. Ia		Silve	r Spring If Under 24 Hrs.	8 Date of Bir	rth	Montgo	<i>y</i>
100	Funeral Director	ř	214-42-6719	1X M 2□F	63	Yrs.	Months Days	Hours Min.	8. Date of Bis (Month, Date 1	ay, Year 5 , 1	943 Was	hplace (State or Foreign untry) hington DC
	land ow at		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation					10d. Inside City Limits
	e Mary 3a-f sh tified	ctor	Maryland Prince	George's			Hyatts	ville				1√Yes 2□No
	with the	Dire	10e. Street and Number 5406 35th Ave.				10f. Zip Code 207	782		-	itizen of What Co nited St	,
	ems 23	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?		3. 13.	Was Decedent of H		pecify Yes or No		14. Race - Ame Black, White	rican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Ft	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			1□Yes 2XINo	Specify:				White
21215-0036	72 hou 'natura dical E		15. Decedent's l (Specify only highest g	Education rade completed)		16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	kina		Kind of Business/	*
121	within iene. • than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		00 NOT use retired s Represe				nstituti leaning	
nd	tal Hyg d other svent,	Be C	17. Father's Name (First, Middle, Las Herman Rie	st) chard	Thoma		-	18. Mother's Nam		, Maide	n Surname)	
ıryla	should I od Men marke matic e	To	19a. Informant's Name/Relationship		THOMA		ng Address (Street a	Mary	Edi		Geo	
, Ma	and 2 sealth ar		Cheryl M. Kucsen			13010	Peaceful	Terrace				
Baltimore, Maryland	ages 1 nt of He : If iten		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3				sition (Name of natory or other plac	,	ber 11,		ocation - City or	
altin	mit. Pa partmer portant / injury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lip		1382	22	1n Cemete Name and Addres	s of Facility	006		rentwood	, MD
ä	permi Depa Impo any in			warm			Rapp Fune 933 Gist	Ave., Si	lver Sp	ring	vices • MD	20910
32	Physician	ei S	23a. Part1. Enter the disease, or con shock, or heart fallure. List onl Immediate Cause (Final					g, such as cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as		Cirrha ence of):	osis					
	Lxaiiiiiei	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as	a conseque	ence of):						
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
68760, <	tificate be executed g physician and as the burial-transit	al Ey	rosuming in death) East	Due to (or as	a conseque	ence of):						
		Medical	IF FEMALE:									
Box	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal of	death 3□	Ectopic pregnancy Other (specify)			1	23d. Date of deli Month	very Day Year
P. O.	that the de led by the a detached f	hysi	9 □ Unknown	9□Unknown								
ds,	signed d be de		Part II. Other significant conditions	contributing to death be	ut not result	ting in the ur	nderlying cause give	en in Part I.	23e. Did t			the cause of death?
Records,	law require as been sig 2 should b	Completed							24a. Was	an	24b. Were au	topsy findings available
a E		Com							auto perfo 1∐ Yes	psy ormed? 2. [X]N∈	death?	ompletion of cause of 2□No
Vital	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital:	ent 2□E	R/Outpatien	t 3 DOA Othe	26. Place of Deater:			6 □Other (Spec	vifu)
o u	Attending Physician: r death. ector: After this certific. by the funeral director,		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	y Year)	28b. Time of Injury	Work	at	28d. Describe			1197
Division or	or Attending Phater death. Director: After the in by the funeral	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not lead to determine determined	be 28e. Place of inju			M 1 □ 1	Yes 2□No	28f. Location (Street a	nd Number or Ru	ral Route Number,
Ö	ital or irs after ral Dire		T	building, ea					City or To			
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 △ Certifying F 2 ☐ Medical Example 1	Physician: To the best of aminer: On the basis of and manner sta	f examination	ledge, death on and/or inv	occurred at the ting estigation, in my of	ne, date and place, pinion, death occu	, and due to the rred at the time,	cause(s date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	0 0		7	29c. License				ate signed (Month	
		-	30. Name and address of person who	Keg	all liters	10	<i>y</i>	2261		UC.	tober 5,	2006
	10		Alan R. Seagal	M.D.; 15	00 Fo	rest (Glen Rd.	Silver Sp	oring, N	4D	20904	
	Sta Registr		31. Date filed (Month, Day, Year)	006 32. 36 gistra	ar's Signatu		arte					

			_ State	aryland / Depa <i>Cer</i>	artment of He tificate of D			2.0	06 31999
			Registrar 1. Decedent's Name (First, Middle, Last)	timodic of E		2. Date of Death			
	Physicia	an		Ψ			Month	Day 2	Year
Ÿ	/Medic		Alfred Lee Aa. Facility Name (If not institution, give street and number)	Towers	4b. City, Town, or	Location of Death	October	8 , 2 4c. County	006 2;25 A [™]
	Examin	er	22 W. Furnace Branch Road		Glen Bur			1	Arudel
				e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
	Funeral Director		217-12-4177 1XM 2□F	82 Yrs.	Months Days	Hours Min.	(Month, Day, July 29,	Year) 1924	Country) MD
			Usual Residence of Decedent				Dury 25,	1727	1110
3	M 1	Ì	10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
-	100	to	MD Anne Arundel	Glen Burn	nie				1 ☐ Yes 21 No
4	288	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of \	What Country?
4	38.0		22 W. Furnace Branch Road		21061		τ	J.S.A.	
1	me 23a or 28a-f show	Funeral	11. Marital Status 12. Was Decedent	Ever in U.S. 13. V	Was Decedent of His	spanic Origin? (Sp	pecify Yes or No-		e - American Indian,
0			Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ N	40	1 Yes, specify Cubar		nican, etc.)		ck, White, etc.
3-003e	within 72 hous arest ene. than "natural", or ite	by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1	1 ☐ Yes 2 🔀 No	Specify:		Specify	w White
ָרָ ה	natur East	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa	ition	kina 1	6b. Kind of B	usiness/industry
7	Was e	ple	Elementary/Secondary (0-12) College (1-4or 5	i+) life. [DO NOT use retired))			
7	Hygien Sther th	ő		Pain	iter			Paint	
and	<u> </u>	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, M		ne)
<u>a</u>	should be nd Mental marked o	ဥ	Emmitt Towers				B. Wrote		
	of Health and Ment of Health and Ment litem 27 is marked rother treumatic e		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a				1
≥ .	and n 27 ner tr	٠,	Mrs. Donna Hamilton / Daugl			Branch B			e, MD 21061
ore	or of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, cren	isition (Name of natory or other place	Oct.	12,	Oc. Location -	City or Town, State
Ě,	ment of I		4 ☐ Donation 5 ☐ Other (Specify)		ven Mem.Pa		06 G	len Bu	rnie, MD
saitimore	permit. Page Department important: if eny injury o		21. Signature of Funeral Service Licensee	0011100	2. Name and Addres				1 Home, P.A.
n	20.5 5 8		Sund Shirk	101479 1	Second Av	enue SW	Glen Bur	nie, M	D 21061
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lie	the death. Do not entende.	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
ý.	hysician		Immediate Cause (Final disease or condition	cardid (Effus in	with Car	-diac Ton	marinel	Onset and Death
	/Medical		resulting in death) a. Due to (or as	9.0					
E	Examiner		Es		Bronths				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						
	od ransi	Examine	Cause (Disease or injury that initiated events c.						
Ď	exe en al irial-t	EX	resulting in death) Last Due to (or as	a consequence of):					
9/60	cate be executed physicien and the burial-transit	dical	d						
20	eath certifica attending ph for use as ti	Jed	IF FEMALE:					9	
X OR	death certific e attending p	2	23b. Was decedent pregnant 23c. If yes, outcome		Ectopic pregnancy				ite of delivery onth Day Year
	0 80 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9☐ Unknown	time of death 5	Other (specify)			IVIC	Jilli Day 1961
J.	ine taw requires mat me de tie has been signed by the a vage 2 should be detached to	چ	9 LJ Unknown						
S,	res ma igned b be det	β	Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause give	en in Part I.		_	tribute to the cause of death?
Vital Records,	w require been si should		5				1 ☑ Ye	s 2 No	3 Probably 4 Unknown
ပ္ထ	aw ras be	ple					24a. Was an autopsy	24b.	Were autopsy lindings available prior to completion of cause of
ř	cate has	Completed					perform 1 ☐ Yes 2	ned?	death? 1 ☐ Yes 2 ☑ No
<u> </u>	certificate rector, pag	BeC	25. Was case referred to medical			26. Place of Dea	th (Check only one		
>	× 5 × 5	70 E	examiner? 1 ☐ Yes 2⊠ No Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatien	nt 3 DOA Othe	er: 4 Nursing H	ome Reside	nce 6 🗆 Oth	ner (Specify)
0	ding Fn h. After th funeral		27. Manner of Death 28a. Date of Inju	ry 28b. Time of y Year) Injury	f 28c. Injury Work	at	28d. Describe ho	w injury occur	rred
Division of	death. ctor: Af y the fur	atic	2 Accident investigation			Yes 2 □ No			
<u>\$</u>	or Attendation deation by the	titie	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, et	ury - At home, larm, str. c. (Specify)	reet, factory, office		281. Location (Str City or Town		ber or Rural Route Number,
ā.	rs after rs after ai Dire led in by	Certification:							
	To the Hospital of Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Check only 2 Medical Exeminar On the basis o	f examination and/or in	h occurred at the time vestigation, in my or	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and mate and place.	anner as stated. and due to the cause(s)
	22 c	Medical	one) and manner st						
		1 39	29b. Signature and title of continer	214	29c. License	unuper		ou. Date signe	ed (Month, Day, Year)
L	To the Ho within 24 I To the Fu completel	-	1/200/		X	12 1-1			9-11-
)	within To the comp	-	1/1/20		8)	3755	/ (Octobe	r-9,2006
)	within to the comp	_	30, Name and address of person who completed gause of o	leath (Item 23a) (Type,	Print)	3)55	3	October m 1	2101
	within To the comp		Russin com =	leath (Item 23a) (Type,	Print) Dr.	3)55 10, G/4	2 Com	Jotobe Jord.	2/06/

		4	For State	State of Marylai		artment of H <i>rtificate of I</i>		Mental Hy	/giene	2006	32000
	80 g/g	14	Registrer 1. Decedent's Name (First, Middle, Las	st) ,		rillicate of t	Dealli	2. Date of D Month Crob	eath		3 Time of Death
8	Physici /Medic		Arzo E.	O E. Thomison							6 05:55 RM
	Examin	er	4a. Facility Name (If not institution, give			th		County of Dear			
- Sec.	Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr		irth	9. Birt	thplace (State or Foreign
100	Director		403-44-4814	ØM 2□F 93	Yrs.	Months Days	Hours Mir		9/191		TJY
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	e Man	ctor	MD Howar	Rd Co	dumb	ia					1 Yes 2 No
	with the	Dire	10e. Street and Number	1		10f. Zip Code				izen of What Co	ountry?
	ne 23a	Funeral Director	8706 Airy bri	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or N	us	14. Race - Ame	encan Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Inportant: If item 27 is marked other then "natural", or items 23s or 28s-f show says injury or other traumatic event, the Medical Examinant must be notified at ODGS.	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	rto Rican, etc.)		Black, Whit	e, etc.
2-0	72 hou	eted	15. Decedent's Ed (Specify only highest grad	lucation de completed)	(Give	dent's Usual Occup	durina most of we	orkina	16b. K	ind of Business	Industry
121	within ane. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)		11-		- 0
d 2	illed I Hygir other	Be Co	17. Father's Name (First, Middle, Last)	NA	ICUS	todian	18. Mother's Na	ame (First, Middle		Sumame)	nce
ylar	Menta Menta arked artic ev	To B	Reuben Thom	nison			Mary	Stone			
Maryland 21215-0036	12 should hand 7 lem		19a. Informant's Name/Relationship (7	(1)		ng Address (Street		1 4		or Town, State, 2	Zip Code)
	Healt Healt tem 2		20a. Method of Disposition	(daughter)	Place of Dispo	osition (Name of	Way, C	Date Date		ocation - City or	Town, State
<u>m</u>	Page nent o ant: If ury or		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemoval from State	sestlau	matory or other plac	1	12/2006	Mas	elmHsvil	Ile. MD
Baltimore,	permit. Departr Import eny inj		21. Signature of Funeral Service Licen		2:	2. Name and Address augh Co 15 Patt	ss of Facility Sierce Note	Funeta Pike, Ro	1 SV	c DRE IN	D 21329
*	(R)		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line	th. Do not en	ter the mode of dyin	ig, such as cardia				Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ephi	e suo	ek				Onset and Death
	Examiner		- 1	Due to (or as a conse	querice of): NUV	ud					
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):	entrer					
	ificate be executed g physicien and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse		muer					
68760,	e be e. rsicien e buria	calE	l	d.	, , , , , , , , , , , , , , , , , , , ,						
_	To on	Medical	IF FEMALE:							Manage Control	
Box	es thet the death certifi igned by the attending to be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of a 9 Unknown	aldeath 3	□Ectopic pregnancy □ Other (specify)			:	23d. Date of del Month	livery Day Year
P.O.	thet the	Phy	9 ☐ Unknown Part II. Other significant conditions or		sulting in the u	inderlying cause give	en in Part I	23e. Did	tobacco i	use contribute to	the cause of death?
ords,	w requires been sign should be	ted by									robably 4 Unknown
Division of Vital Records,	G & C	Completed						24a. Was auto perf 1 ☐ Yes	ormed?	prior to death?	utopsy findings available completion of cause of
Vita	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		otho		eath (Check only			
ō	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury	28b. Time o	II 3 DOX	4 🗀 ivursing	Home 5 Res			cify)
sion	ending sath. or: Aft he fun	atio	1. Natural 5 Pending investigation		Injury		Yes 2 □No				
DIX:	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Special	nome, farm, st fy)	reet, factory, office		28f. Location City or To			ural Route Number,
	o the Hospital or Attending Physician: The within 45 bours after death. othe Funeral Director: After this certificate his completely filled in by the funeral director, page to make the filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 2 Medical Exam	ysicien: To the best of my kn niner: On the basis of examin- and manner stated.	owledge, deat ation and/or in	th occurred at the fin evestigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time	cause(s) , date and	and manner as I place, and due	s stated. to the cause(s)
.	To the I	Me	29b. Signature and title of certifier	Ma	•	29c. Licenso	e number		29d. Dai	te signed (Monte	The Day Year)
1)		30. Name and address of person who of CUCON And CONTROL (1997)	completed cause of death (Ite	m 23a) (Type,	Print) Bell	lane	da	elis	ulle	MD 21029
	>	te	or all the (month, buy, rour)	OL. programar a orgin	ature	1 60 .					
40	Registr	ar	OCT 1 0 20	106 / 1081000.	B. A						